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# FAITH, ITS GENESIS AND ITS FUNCTION IN PSYCHOTHERAPY

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Through the years a wide variety of methods, theories, and techniques have been used to treat the mentally ill. Even today therapeutic techniques range from pre-frontal lobotomies to tranquilizers, from faith-healing to psychoanalysis. Each method has its adherents and each purports to be based on what we know of the brain and its function—mind. Many of these techniques of treatment seem to have little in common except the extraordinary and rather surprising fact that they are all, more or less, successful in relieving symptoms. When diametrically opposed types of treatment relieve symptoms, in similar cases, one wonders if perhaps something other than the method may have produced the results. Bromberg,[1] Masserman,[2] and others have advanced various explanations for this phenomenon. One of several such observations is that faith functions as a part of therapy. However, little has been written concerning the genesis and function of faith.

[1]Walter Bromberg, *Man above Humanity,* J. B. Lippincott, Philadelphia, 1954.
[2]Jules Masserman, "Faith and Delusion in Psychotherapy," *American Journal of Psychiatry,* CX (1953), No. 5, 324-333.

The history of psychotherapy shows that early attempts at treatment involved the use of magic. Even today, magic as a form of therapy is not uncommon, occurring in healing through super-naturalism and occultism. Often magic is an unconscious factor in psychotherapy on the part of the patient, as any therapist can affirm. Magic may be defined as a hope for, and belief in, the impossible. It denies reality and is dependent upon distorted interpretations of perceptions. In therapy, magic represents an attitude of the patient who hopes for results, no matter how impossible, and without self-involvement. It ignores the reality of perceptions and forms the basis for man's most primitive psychic defenses, denial, introjection, and projection. Psychologically, magic is related to faith insofar as both are dependent on some outside source for gratification. Faith, while it may be considered a modification of magical thinking, has the significant difference that its premises are not regarded as illusory, but as within the realm of possibility. Ducasse has defined faith as meaning "not only (*a*) a very firm belief, either unsupported or insufficiently supported by evidence; but in addition either (*b*) that the content of the belief tends to be made true by the very act of believing it firmly or (*c*) that the content of the belief is of such nature that firm belief of it tends to have certain valuable results."[3] Like magic, faith must have an object, but the object of faith is, generally, more creditable than that of magic and involves a closer relationship.

It has been my privilege, over a period of years, to have treated a number of ministers, seminary students, missionaries, and religious educators to whom the question of religious faith and belief in God was important. This stimulated interest in a study of faith from the psychological point of view. Some insight was obtained concerning the process of faith, its genetic antecedents, and its development as a factor in personality structure.

With the ministers and the other theologically oriented persons the question of faith centered around a belief in God. God was usually considered as something unexplainable, omnipotent, omniscient, loving, giving, and outside the individual. Freud has related the concept of God to a projection of the father-image. This projection of the father-image was quite apparent in the similarity between descriptions of the fathers of the individuals studied and their descriptions of God. God is often referred to as "God the Father." Christians pray to "Our Father which art in Heaven." But God is more than a simple father-project. Maloney recognized that the concept of God also contains a mother-image which he relates to the formation of the super-ego.[4] Beyond this there is a third factor in which God represents the self—the omnipotent infantile self. This fantasy seems to be universally present as an integral part of our character

[3]C. J. Ducasse, *A Philosophical Scrutiny of Religion,* Ronald Press, New York, 1953.
[4]J. C. Maloney, in *Journal of the American Psychoanalytic Association,* II (1954), No. 1, 120-151.

structure, involved in what Masserman calls the "Ur-defenses."[5]

To hypothecate concerning the genesis of faith, consider an infant, helpless and dependent upon others for his existence. If his basic needs are not satisfied, he dies. Some of these needs are instinctively satisfied by himself (e.g., breathing, elimination), while others must be satisfied for him (e.g., hunger). As the infant experiences temporary frustrations of its dependent needs, it is forced to an awareness of objects. This results in the eventual differentiation of the self from the non-self. It has, perhaps, several other implications. First, the frustration shakes his omnipotent belief in himself, emphasizes his dependency, and results in fear. Secondly, the frustration produces anger toward the object of dependency. When the object satisfies him he is content, when it frustrates he is angry and we have the beginnings of ambivalence. Thirdly, insofar as he is eventually satisfied, he transfers the belief in his own omnipotence onto the object of his dependency. The fear seems to be a basic fear of death to which is added the fear of the destructiveness of the anger which would remove the object of dependency and thus eventually be self-destructive. But the dependent object also is the source of gratification which eventually develops into love toward the object. Thus early in personality development, the individual, when confronted with the fact of his own helplessness and because of the anxiety this engenders, transfers the belief in omnipotence to those he loves, but on whom he is fearfully dependent. Thus faith begins as a defense against the reality of dependence, fear, and anger and is early associated with gratification and love. In our culture mother is the first object of faith, dependency, love, fear, and anger. As the child matures, others pre-empt her place. Generally father succeeds mother, but he also loses the displaced omnipotence and an even more powerful source of relief from anxiety is sought in the belief in a diety.

So far, this belief of the infant and child—this faith in one's own omnipotence or in the omnipotence of the parents—is delusional in that it is a false belief used to protect the self against the reality of dependency and fear of death. It is not delusional in the sense that it represents a hope for dependent gratification based on the experience that the wishes will be satisfied sooner or later by the loving, giving parents. As the child continues to grow and mature, physically and emotionally, becoming less dependent upon others for satisfactions and actively striving for independence, his faith also changes. Rather than being a protection against overwhelming anger and fear at loss of dependency and threat of death, it becomes an anticipation for future satisfaction which may be realized by his independent activity. With maturation comes the realization that one can achieve that which, as a child, he had depended upon others to give. With maturity comes the ability to make faith a reality. Faith thus becomes an expression of the recognition of the self as a productive, creative individual able to satisfy needs by active objective mastery of the environment

[5]Masserman, *op. cit.*

or realistic adaption to it. Rather than being a projection of the self used defensively, faith is concerned with realistic self-evaluation of individual potentialities.

With increasing age and waning activity, there may be a further change. Again the individual is confronted with the possibility of dependency. Further, insofar as the creative activity, the dreams, and goals were only partially realized, there often is a sense of frustration and anger with the awareness that they probably never will be satisfied. But perhaps more than this is the reality of approaching death. Once again surcease is found in a faith which denies death, offers hope of satisfactions, allays the anxiety of the unknown, and the cycle is complete. Faith thus may pass through various stages from a defense, to a hope, to reality, to hope, and finally to a defense. It seems to be linked to the developmental and maturational process of the ego and, since this is the case, is liable to the vicissitudes which affect ego-development. Thus we can expect aberrations of development to affect faith as they affect ego-maturation. The psychotic individual often uses religious faith as a defense which may be delusional. In the neurotic it may become a source of dependent gratification or a reaction-formation against hostility, etc., and must be protected and defended. If faith is used defensively, we might expect to find evidences of disturbance and resort to this mechanism during periods of stress. Erikson[6] and Carlson,[7] for example, have independently described a condition appearing in adolescence when the ego is faced with decisions as to adulthood. There is at this time rebellion against parental mores, preoccupation with philosophical questions of truth, the meaning of existence, as well as increased responsibilities, seeking of work goals, competition for a mate, and the like. If the ego is weak, past defenses may be inadequate, resulting in a period of confusion. Religious faith may be one of the attempts at resolution.

An 18-year-old freshman college student suffering from an acute confusional syndrome will serve to illustrate this use of faith. Briefly, Fran was the oldest of two children born in a well-to-do Midwestern family. Father was a successful lawyer, active in community affairs, who demanded excellence from his children. Mother was his intellectual inferior who achieved status through her many social and religious activities. Fran was a leader in high-school activities. She was a brilliant student. Competition between Fran and her brother was intense in all areas of their lives. While in college, as a result of a sexual commitment and concern about her studies, she became anxious, depressed, and confused. After being seen at the student health service, she was sent home with the rcommenda-

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[6]E. H. Erikson, "On the Sense of Inner Identity," in Vol. I of *Psychoanalytic Psychiatry and Psychology,* Austen Riggs Center, edited by R. P. Knight and C. R. Friedman, International Universities Press, New York, 1954, pp. 351-264.
[7]H. B. Carlson, "Characteristics of an Acute Confusional State in College Students," *American Journal of Psychiatry,* CXIV (1958), No. 10.
[8]Bromberg, *op. cit.*

tion that she have psychiatric care. After about two months of supportive treatment and for a variety of motives, the suggestion was made that she re-read 1 Corinthians 13. That night she did and had an experience which she wrote about the next morning.

Saint Paul, in his deep understanding of God and man, gave us these words to guide our faith. Yet, how many times have we heard them without really hearing them? So many of us have not "put away childish things," and thus are unable to know the full impact of these lines on our lives. The experience which I shall relate is one which has had and, I feel, will continue to have more influence on my life than any other happening. To say I have entirely put away childish things would be foolhardy, as it would likewise be if I should proclaim that I shall ever fully achieve this end. Yet, what I shall tell you is the beginning, a vital step toward a better understanding of God, man, and myself.

"When I was a child, I spake as a child, I understood as a child, I thought as a child": As a child, growing up in a Christian home, I learned of God through Christ and His teachings. Just as the babe accepts the existence of a Santa Claus, as told him by his parents, I accepted the concept of God as He was presented to me in church. This was the beginning. My faith was infantile, blind, unthinking, unquestioning; but it was adequate to serve the needs of childhood, and as I grew older this faith remained firmly implanted in me—a very part of my life.

Then, this year, my faith collapsed. Doubts arose, unanswered questions appeared; I was terrified and bitterly disillusioned. I felt alone, desperately alone. My faith no longer was sufficient to meet the growing needs of an adult. I felt that now, especially, I needed God, but that He was not there. I prayed for guidance, asking repeatedly that God show me the Way, the meaning of my life. Yet, the peace which prayer had given me in childhood no longer existed.

I sought God one rainy night in His chapel at school, feeling that here I might find Him again, and restore the faith which had been mine. In my eagerness I ran; anticipation propelled me forward. Running up the chapel stairs, I lunged for the door; it was locked; all the doors were locked. I didn't know where to turn, what to do. Was not the Lord's house always open? Why had I been so cruelly shut out?

At home I went to church—my church. Here I could find God. Kneeling down, I prayed as I had never prayed before; I begged God to hear me; yet the words seemed to echo in my own mind and go no further. I was separated from God and, in a very real sense, experiencing Hell.

Countless questions followed. I tried to suppress them, to deny to myself and God that they were present; but they persisted. Feeling ashamed, I condemned myself for daring to doubt the faith of my childhood. Doubt to me was the worst form of sin. Only later was

I to learn that through sincere questioning we grow, cementing an adult faith.

My doubts grew, driving me further from God. What was the meaning of Creation? Why was I born? What was God's purpose for me? Plunging deeper into my thoughts, I wondered if there really was a God at all. Was He, rather, devised and created first in man's minds to fulfill a need for the supernatural—a need for someone better than man to combat his feeling of aloneness; or was He needed by men simply to explain those natural phenomena which had no apparent explanation?

Although these thoughts passed through my mind, I could not deny the existence of God, the First Cause, the Creator. But is He a personal God? Does He really care about me? Perhaps He was simply the Master Watchmaker who, having created His masterpiece of intricate workmanship, wound it up, and left it to run for all time. This was the great question; my whole Christian faith hinged upon it; yet I had no answer. I could neither prove nor disprove the existence of a personal God.

If God did love and care for mankind, then I found it conceivable that He should speak to us through Moses and the Prophets to tell us his will; and, seeing man go astray, come to earth himself in the form of a man—Jesus of Nazareth—to show us through His humility and the supreme sacrifice on the Cross that God forgives the sins of man; and, by His resurrection promise salvation to those who do His will.

If there is salvation as Christ promised, what is the nature of Heaven, and is there a Hell? If God is love, how can He punish man for his sins? My childish concept of Heaven as a place where the good may see God sitting on a throne, surrounded by angels, was no longer acceptable to me; yet, there was nothing to fill the vacuum which this created.

I went to see my priest, and though I told him none of my questions, he seemed to sense my anxiety. Before I left, he told me this, words which gave me hope, for I believed them. He said that, although I didn't know it, God was with me at this time. I clung stubbornly to these words while the conflict within me continued to surge.

Then it happened; it was not a miracle. God did not appear in a vision, pointing out the road for me to take (as I in my childish faith had supposed). It came in the form of a realization that God was with me, and had been beside me throughout this period of despair; but, in my selfish concern for myself, I had shut him out—I had been unaware of His presence. My thoughts and prayers, in the normal self-concern of childhood, had formed a concept of God according to my own needs. I had been thinking of God in terms of His serving me, rather than in terms of my serving Him. Now I was partially able to put away childish things.

My faith began to be restored, or rather, to be renewed. It was

no longer the faith of a child, but a fuller, stronger faith. A friend once said to me that she longed for the faith she had experienced as a child, a faith which knew nothing beyond itself; one which did not know the bitterness of doubt, the anxiety of questioning. I feel, however, that the faith which dares to doubt, to seek, to find, can be far richer and have a more constant, unswerving impact on one's life. It has nothing to fear, for it has the gift of understanding.

Saint Paul said, "For now we see through a glass, darkly, but then face to face. Now I know in part, but then shall I know even as I am known." I could no longer question the existence of God, or His concern for me, since I felt God within me—a kind of inner peace, a feeling of togetherness with God. Here on earth we can only hope to "see through a glass, darkly." We can know through prayer and service to man in part the supreme peace which comes to the spirit from God—"but then face to face." Because of Jesus' resurrection, we are promised everlasting life. He never defined Heaven, nor can we hope to know it in our lives on earth. I do not think of Heaven as a place, nor of salvation in bodily form, but perhaps the beginning may be found here on earth—in the peace of spirit which we experience through God. Perhaps this is how we know in part; but then "shall I know even as I also am known"—an understanding of God through a clearer image in His mirror (glass), which is not possible now, is possible in eternity.

"And now abideth faith, hope, charity, these three; but the greatest of these is charity." Herein, I feel, lies the answer to my question of God's purpose for us. Faith in God, hope of everlasting life through Christ, but most important, charity. It is interesting that the term charity was employed in place of love in the King James version of the Bible. But is it so strange? Isn't love in the broad sense, a giving of one's self to others? Here on earth we cannot love God or our fellow man as God loves us, but we can "know in part."

I believe that the closest man can come to the fulfilment of Christian love here on earth is in the marriage relationship. "But then shall I know even as I also am known." No man can know us as God does. Few of us are willing to know ourselves as He does, but in the man-woman relationship this can be approached. For in deep love one desires not only to know the other person fully, but to be known—to become, as it were, one. In doing so, love becomes a reality, and giving synonymous with receiving; the lover's kinship, ideas, desires, thoughts, become more important than our own. But, just as one must be honest with God, and his fellow man, he must be honest with himself. "Know thyself"; and I shall add "love thyself," for, unless one can love himself, he cannot love another. A love of one's self is different from conceit or egotism, just as true humility and a feeling of inferiority oppose each other. Love cannot be defined, just as God who is love cannot be measured; yet, we can feel love. We are commanded to "Love thy neighbor as thyself." How can we hope to love our neighbor fully if we cannot first love ourself? Through love—of God, of man, of self—we can carry God's

word to others; and, through our love, hope to show others a very small part of God's love for all mankind.

Theologically, this patient might be said to have had a religious experience. Psychologically, she had a reintegration of her mental functioning within the framework of her religious belief. Her unconscious reason for using this framework is understood when it is realized that throughout her life the church was the only place she felt secure and accepted. Her mother had rejected her and her father accepted her only on the condition that she excel in school. In the period of crisis she used the only frame of reference she could—her religious belief. For her it worked and she was able to function once again at a level which was more mature than the previous one. Her faith became an affirmation of herself. This I think is the ultimate meaning of realistic faith—self-affirmation. Treatment did not stop with this experience, of course, but continued with the analyzing of the meaning of her symbolization, which occupied the next several months. This added understanding helped consolidate the integrative process and she returned to school.

We have seen how faith can function in terms of individual ego-process and have hypothecated as to its antecedents and genesis. Let us then consider briefly faith as a factor in psychotherapy, remembering that realistic faith was defined as self-affirmation.

Psychotherapeutic processes, generally, involve a relationship between two people—the patient and the physician. (Group therapy and treatment involving more than two people are considered modifications of this fundamental relationship.) Therapy usually begins and continues because one person is sick and hopes the other can help him. For purposes of discussion, we shall ignore other complicating factors, conscious and unconscious, which lead people to seek treatment and which are involved in the therapeutic process. We must also limit our discussion to the factor of faith, since to become involved in the complexities of psychotherapy is beyond the scope of this brief paper. Also, for simplicity, psychotherapy will be divided into two general types: supportive and interpretive. Supportive therapy includes all forms of treatment which limit or inhibit attempts at understanding symptomatology and process connections, while interpretive therapy encourages such understanding, regardless of the particular frame of reference of the therapist.

The aim of supportive therapy is to help the patient by relieving his symptoms. This is accomplished, generally, by the therapist's doing something to or for the patient. But before this can occur it is necessary for the therapist to instill in the patient, if it is not already present, a belief that he will eventually be helped. This belief involves an external object (the therapist) which will work the changes in the patient necessary for relief of symptoms. To achieve this result, the external object effecting this relief is invested by the patient with authority, knowledge, and a desire

to help. Therapy of the supportive type assumes that the patient wishes to change. It demands of the patient a passive, submissive acceptance of the external object, which will make the change in the patient by virtue of its authority, knowledge, and desire to help. Bromberg, who was paraphrased in the preceding discussion of supportive therapy, observes that, in many respects, supportive therapy is analogous to the process of prayer where an appeal is made to God (the external object) to do something to or for the supplicant.[8] Prayer is based on the belief that God's omnipotence and omniscience will be at the disposal of those who, through willing submission, accept the knowledge and power of God, and by thus believing and submitting have their wishes granted. Supportive therapy demands of the patient passive submissiveness to the treatment of the physician who, because of his training, believes he can help the patient. It is often amazing to see the things people will submit to because of their desire to be helped and their dependent faith in the therapist and his beliefs.

Interpretive therapy has the same pragmatic aim as that of supportive treatment—the alleviation of symptoms. It differs from supportive treatment in that it uses scientific methodology to understand causal relationships between intrapsychic processes and symptom formation. Interpretive treatment further differs from supportive therapy in that it achieves its aim by dealing with the etiological causes rather than with symptoms per se. It recognizes the multiplicity and interaction of etiological factors and the complexity of intrapsychic forces. It is predicated on the belief of the physician that he can determine the processes involved from his study of the patient. This belief becomes a factor in treatment as the physician and patient work together helping the patient relearn attitudes, modify behavior, and integrate instinctual forces into the total personality. Treatment may be accomplished from one of several frames of reference. A little reflection will show that, to the patient, the frame of reference of the physician is not necessarily of import as long as the patient obtains the relief he seeks.

To the therapist, the belief as to the causation of symptoms is important since it directly affects his philosophy and technique of treatment. This belief is based upon his observations of patients, upon what he has been taught, the results of his own introspection or analysis, and the pragmatic fact that use of this method has relieved patients of their symptoms. Further, the belief in the scientific certainty of the cause of symptoms is psychologically important to the therapist, since it gives him a feeling of security. This sense of security and the nature of the therapist's faith in his system of treatment are factors in therapy which are deeply reassuring to the patient, regardless of the particular therapeutic "school" of the physician.

Essentially, however, though therapeutic methods vary, the medium

[8]Bromberg, *op. cit.*

through which change occurs is the mind of the patient. We know some things about ego-functioning. We speculate and theorize concerning dynamic mental processes, but we cannot as yet state with certainty how symptoms are removed by the patient. We know that such removal involves psychological mechanisms and socio-philosophic values. Integration of instinctual energy into acceptable expressions and behavior governed by reality necessitates philosophic and social value-judgments. One factor influencing such value-judgments is the faith of the individual. This is as true of the therapist as it is of the patient. However objective he may be, the physician's faith, his value-judgments, are pertinent forces, consciously or unconsciously, in the treatment of a patient, regardless of the method employed. Associated with value-judgments and faith is the wish to help. The belief that he can help the patient is a function of the therapist. It is an interesting observation that the therapist can help only those whom he believes he can help. The method by which this belief is mediated serves as a frame of reference and increases the sense of security of the therapist. While it seems to be true that some methods are more effective than others, it is also true that the belief of the therapist directly influences the efficacy of the method. Further, the therapist's belief serves the same dynamic function in himself as it does in the patient. It helps alleviate the anxiety resulting from the recognition of one's ultimate vulnerability, dependency, and mortality. Each time therapy is successful, it is reassuring to the therapist, since it reaffirms his faith in himself. It is comforting to know that one can meet and master, or accept and adapt objectively to, the vicissitudes of life. It is equally comforting to help someone else do this.

When considering the factor of faith in therapy, it is well to remember that there is a significant difference between the patient and the physician. This difference is dynamically important. It is the difference between mother and child, the recipient and donor. We have mentioned earlier that relief from symptoms is, in part, dependent upon the belief of the patient that he will be helped. In supportive therapy, this belief is reinforced insofar as the physician does something to or for the patient which relieves the symptoms. With interpretive therapy, the situation is rather more complicated. The physician, instead of doing something directly to or for the patient, insists that the patient know and help himself. When this is accomplished, as part of the integrative functioning of the ego, the individual can become creative and productive in his own right. To achieve this, the patient, among other dynamic processes, passes through the various phases of the development of faith coincidental with the transference. Early, he believes in the omnipotent authority and knowledge of the therapist and reacts on the basis of that faith. This usually results in an initial relief of symptoms. As treatment progresses, the symptoms, and others, recur and occur and the real work of therapy proceeds. With demonstration and analysis of the transference and resistances, the patient begins to accept and relate to the therapist as an individual. He acquires self-knowledge and self-acceptance. By relearning, the patient is able to modify and

adapt previous attitudes and responses to his current life-situation. With the strengthening of the ego, it becomes unnecessary to rely upon the support of others and the initial dependent faith becomes a realistic evaluation of the self. The individual is able to realize more fully his potential, and his faith becomes an objective awareness of his relationship to others.

Faith may be considered as a part of the dynamic process of mentation related to ego-functioning and, as such, passes through various phases of development associated with the formation of character structure. It is one of several factors in therapy which influence the physician's technique as well as the patient's responses. Therapy modifies the fantastic beliefs of the child toward a more realistic self-concept. Faith may be defined as self-affirmation and, as such, states "I am what I am", not "I am more or less than I am."

# SOME FURTHER OBSERVATIONS ON SIN AND SICKNESS

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A few years ago a popular magazine carried an article entitled "Are Prisons Obsolete?" Most people now recognize the fact that alcoholism is the symptom of sickness. Parents and undesirable environments are blamed now for juvenile delinquency. More and more of what has traditionally been called sin is now seen as the consequence of factors beyond the individual's control. Christians nurtured in a doctrine of original sin, which proclaims the inherent evil of all men, and faced with the church's usual catalogue of vices to be avoided, are understandably confused by the findings of psychology. Is all sin, crime, and vice now to be regarded as the result of profound illness? If not, where do we draw the line which separates sin from sickness? If so, how does such a concept affect our methods of dealing with the problems?

In a 1956 issue of this *Journal,* R. Lofton Hudson[1] summarized with eight points the relationship between sin and sickness: (1) Sin and sickness may enter into and influence the same act. (2) Sin may cause illness and illness may contribute to sin. (3) Emotional illness may need to be treated before sin can be faced. (4) Anxiety and awareness are involved in both health and righteousness. (5) Both sin and sickness involve intrapsychic problems and interpersonal disturbances. (6) Both sinners and sick people build defenses against anxiety. (7) The aim of both the psychotherapist and the minister is ego strength. (8) Sometimes it is difficult to determine what part of the individual's behavior problem is due to sin and what is due to illness.

In order to explore the relationship further let us define what psychology or psychoanalysis means by illness and what Christianity means by sin, and then analyze the similarities and differences between the two.

## Sickness

The first task then is to define neurosis.[2] It is fairly easy for most people to understand that the psychotic person is ill. It is often difficult,

[1]R. Lofton Hudson, "Sin and Sickness," *Journal of Pastoral Care,* X (1956), 65-75.
[2]Except where otherwise noted this discussion is based upon Karen Horney's presentation in *The Neurotic Personality of Our Time,* W. W. Norton, New York, 1937.

however, to see that neurotic character disorders in which persons act out impulses and commit crimes are also illness. A distinction should be made between these character disorders where the disturbance lies in a deformation of character and the simple situation neuroses which occur in individuals whose personalities are otherwise sound, when they face an external situation filled with conflicts. We are concerned here with the character disorder begun in childhood and involving large sections of the personality. Although there are many different symptoms of neuroses, it will be sufficient here to describe only the characteristics common to all neuroses.

There are two characteristics discernible in all neuroses: a certain rigidity in reaction and a discrepancy between potentialities and accomplishments. Rigidity means a lack of the ability to react differently to different situations. An example is the difference between the normal person who is suspicious where he sees reasons for being so and the neurotic person who may be suspicious all the time regardless of the situation.

In the dynamics effective in producing neuroses there is one essential factor common to all neuroses—anxieties and the defenses built up against them. Anxiety is "the motor which sets the neurotic process going and keeps it in motion."[3] This statement should be qualified by saying that not all fear and defense mechanisms are neurotic. A distinction will be made later between fear and anxiety. There are, however, two factors which distinguish the neurotic type of fear and defense. First, all cultures give rise to some unavoidable fears; the neurotic not only shares these common fears but also has fears which in quantity or quality deviate from those of the cultural pattern. Second, the fears of any given culture are handled by protective devices—taboos, rites, customs—so that a normal person is capable of living up to his potential in his culture. He does not suffer any more than is unavoidable. The neurotic, however, suffers more than the average person because his defenses are less economical, more costly in terms of vitality and impairment of his capacities for achievement. A neurosis, however, cannot be described via psychological or sociological tools alone; the two approaches must be combined. Neuroses can be regarded neither as mere deviation from a "normal human being" (who does not exist), nor as mere deviation from the behavior pattern common to a certain society.

There is one further essential characteristic of neuroses—the presence of unconscious conflicts, distinguished in the neurotic by the fact that they are sharper and more accentuated, and that the solutions are achieved at great expense to the whole personality. The conflicts are basically similar in content in all neurotics. The similarity is not in the experiences which have prompted the disturbance but in the actual conflicts moving the person. This interpretation deviates from the Freudian view which places the

[3] *Ibid.*

main emphasis on the sexual roots or infantile pattern of an impulse. While the analysis is not complete without this tracing back to infantile conditions, the actually existing unconscious tendencies should not be neglected. Conflicts revolve around "First, attitudes concerning giving and getting affection; second, attitudes concerning evaluation of the self; third, attitudes concerning self-assertion; fourth, aggression; fifth, sexuality."[4]

Since anxiety is the central factor in neurosis, we must make a distinction between normal fears and neurotic anxiety. It is not enough to say that fear is a reaction proportionate to the danger one has to face, while anxiety is a disproportionate reaction to danger. Actually both fear and anxiety are proportionate reactions. In the case of fear the danger is an objective one, whereas in the case of anxiety it is hidden and subjective. The intensity of the anxiety is proportionate to the meaning the situation has for the person concerned, even though the reasons for it are essentially unknown to him. It is this fact which makes it impossible to argue a neurotic out of his anxiety.

There are several other points concerning anxiety which have important implications for our topic. First, not only can we have anxiety without knowing it, but it may even be the determining factor in our lives without our being conscious of it. Another element is its irrationality. Connected with this irrationality is the fact that anxiety is "an implicit admonition that something within us is out of gear." Since the neurotic person does not like this challenge, he tries to escape the anxiety. In our culture there are four main ways of escaping anxiety: "rationalize it; deny it; narcotize it; avoid thoughts, feelings, impulses and situations which might arouse it."[5]

Roberts states the characteristics of neuroses in different words, but points to the same phenomena.[6] He refers to the rigidity of the neurotic as "internalized standards which function automatically." He also calls attention to the repressed impulses which sabotage conscious effort and come to the surface in such symptoms as involuntary rage. Conflicts are described as estrangement between the unconscious and the conscious parts of the self. The ego is "squeezed" when the individual is driven by automatic standards and repressed impulses, and the person experiences anxiety. Basically the neurotic person is one who is not free. There is one further point which has not yet been emphasized—that the neurotic person is estranged from parts of his inner self and consequently from other persons as well. "The inward conflict is so directly related to estrangement from others that whatever intensifies one will intensify both."[7]

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[4] *Ibid.*
[5] *Ibid.*, p. 35.
[6] D. E. Roberts, *Psychotherapy and a Christian View of Man,* Charles Scribner's Sons, New York, 1950.
[7] *Ibid.*, Chap. II.

Before going on to a definition of sin, it is necessary to consider the problem of neurotic guilt. Many people have seen in this problem the most plausible connection between psychotherapy and religion. There is much evidence of the existence and crippling effect of guilt in neurotic persons. The question arises as to whether the conscious feelings and the symptoms indicative of unconscious guilt cannot be interpreted in some other way. Several factors give rise to such a question. The first is that the so-called guilt feelings are not unwelcome, that in fact the neurotic person insists upon his guilt and resists every effort to exonerate him. Real guilt is painful and expressing it to another person even more painful. Moreover, the self-recriminations of the neurotic are characterized by distinctly irrational elements which range from gross exaggeration to sheer fantasy. The neurotic person also resents anyone's taking his self-accusations seriously. Much of what appears to be guilt is really the expression of anxiety or of a defense against it. Guilt feelings are closely connected to the fear of disapproval, and it is possible that they are the result rather than the cause of this fear. Such feelings also serve as a defense against the fear of disapproval and they invite reassurance by blurring the real issue. They also prevent the neurotic from seeing the necessity for change, and in fact serve as a substitute for change. Finally, self-recriminations serve to ward off the danger of accusing others, because inhibitions toward criticizing others reinforce the tendency to accuse oneself. This distinction between real guilt and the so-called guilt feelings of the neurotic person will be important in discussing the relationship between sin and sickness.

## Sin

A Christian definition of sin depends upon our interpretation of the Adam and Eve myth in Genesis. The story makes man very definitely responsible for the entrance of sin into the world; on the other hand, it involves all men in the consequences of the sin of the "first" man. Thus is provided the source of tension which has disturbed Christians for centuries. Is man to be held responsible for the state of sin in which he finds himself, or can he blame Adam through heredity? Is man capable of not sinning or is he "not able not to sin?" Can he save himself or is he so entangled in the sin of the race that only a divine gift of grace can save him?

The traditional interpretation or doctrine of original sin based upon Rom. 5:12-13, 18-19, affirms that all men are guilty because of the sin of the first man; that sin is transmitted by heredity through the evil of sexual reproduction and is compounded by the sins of daily life. This formulation should be rejected for several reasons. Brunner points out first of all that such a theory is foreign to the Bible.[8] Rom. 5:12 and Ps. 51 do not say anything about inherited sin through natural descent, or

[8]E. Brunner, *The Christian Doctrine of Creation and Redemption,* Dogmatics: Vol. II, Westminster Press, Philadelphia, 1952, pp. 103-107.

about any connection between sin and conception. Adam's descendants are involved in death because they themselves commit sin. Brunner goes on to blame Augustine for including the Hellenistic depreciation of sex in his idea of sin and points out that this makes sin essentially a life of the senses, whereas in the Bible sin is essentially defiance and arrogance. Moreover, sin is not a quality to be inherited but is something which involves the whole personality, any existence apart from God.

Kierkegaard in his interpretation of the Genesis story used a most significant word—*angst,* which has been translated *dread,* but comes very close to what psychotherapy means by *anxiety.*[9] His interpretation was prophetic in another way also. While he refuses to classify the story as a myth, he emphasizes the importance of Adam as a member of the race and the importance of his predicament as being the same as that of every individual. The substance of the Genesis story is that sin came into the world with the first sin. The same is true of the first sin of any individual. The fact that it had not been there before Adam's sin is an irrelevant reflection. Every person is both an individual and the race—neither an empty repetition of the species nor only an individual. Ignorance or innocence is a state of peace, but it is also a state in which there is nothing to strive for. Such a situation begets dread. Dread is an ambiguous state—either a sweet feeling of apprehension or a feeling of shrinking. The prohibition alarmed Adam and induced a state of dread because it awakened the possibility of freedom. Dread thus is a sort of intermediate state between innocence and sinfulness. It is neither necessity nor freedom. Dread is not the same as fear because it is not connected with anything specific.

It can be seen that Kierkegaard's interpretation, although literalistic and fantastic at points, does keep intact both man's freedom and his responsibility. Moreover, his use of the term *dread* or *anxiety* and his careful distinction between that and fear point to an awareness of man's inner predicament which goes beyond the simple acknowledgment of weakness or lack of absolute freedom.

Tillich feels that today the Genesis story must be interpreted using the analogies of existentialism.[10] He employs the phrase "transition from essence to existence." Like Kierkegaard, he finds in man's very freedom the possibility for this transition. He makes four statements which help to clarify man's predicament: (1) He emphasizes the polarity of freedom and universal destiny. (2) Man's freedom is finite. This finite freedom means that he has language which frees him from bondage to concrete situations; he can receive moral and logical imperatives; he can ask questions about the world which penetrate deeper and deeper; he can play and build and create tools; he can contradict himself. (3) Man is free

[9]S. Kierkegaard, *The Concept of Dread,* Princeton University Press, 1946, pp. 23-46.
[10]The rest of the discussion of sin is based upon P. Tillich's *Systematic Theology,* Vol. II, University of Chicago Press, 1957, pp. 29-78.

to surrender his humanity. (4) All this freedom is limited by or works within the framework of a universal destiny. It is the very Image of God in man which provides the possibility of the Fall. Existence is rooted in this combination of ethical freedom and tragic destiny, and the human situation is incomprehensible when either factor is denied.

Creation and the Fall coincide. Actualized creation and estranged existence are identical and while creation is good in its essential character, if actualized it falls into universal estrangement from God through freedom and destiny.

The state of existence then is the state of estrangement. The profundity of the term "estrangement" lies in the implication that one belongs essentially to that from which one is estranged. Estrangement is not a biblical term, but it is implied in the expulsion from paradise, the hostility between man and nature, the confusion of language, etc. "Sin" is the biblical word for estrangement, but it has been used too often to denote "sins," deviations from moral laws. This has little to do with *sin* as estrangement. "Sins" are rather the expressions of "sin" and it is not the disobedience to a law which makes an act sinful, but the fact that it is an expression of man's estrangement from God, from men, and from himself.

Estrangement can be defined as unbelief, "the act in which man in the totality of his being turns away from God"; as *hubris,* the act "in which he makes himself the center of himself and of his world"; and as concupiscence, the unlimited striving for knowledge, sex, and power, such as is described by Freud's "libido" and Nietzsche's "will-to-power," which, while not themselves characteristics of concupiscence, become expressions of it when not united with love.

Tillich uses the word *evil* to denote the consequences of the state of sin and estrangement for purposes of clarity, but he describes evil as "the structure of self destruction which is implicit in the nature of universal estrangement." His elaboration of the nature of evil includes the following topics which will give some idea of its content—death, finitude and guilt; estrangement, time, and space; suffering and loneliness; doubt and meaninglessness. These structures of evil drive man to despair.

### The Relationship between Sin and Sickness

It can be seen from these descriptions of neurosis and sin that they have in common the problem of determinism vs. responsibility. Neither religion nor psychology aligns itself on one or the other side; both recognize the reality of both aspects of man's situation. "Why it is often assumed that theology demands absolute freedom and psychiatry insists upon absolute determinism remains one of the minor mysteries."[11]

[11]R. A. Preston, "Interrelating Psychiatric and Religious Ideas," *Journal of Pastoral Care,* X (1956), 27-33.

The relationship is not as simple or as happy as this statement would lead us to believe. Since man is too intricate to be described in "either-or" categories whether by religion or psychology, we can find contrasts and parallels between both moralism and psychology and between original sin and psychology. There seems to be only one point at which psychoanalysis is in agreement with moralistic religion and that is in the awareness that man must take responsibility for his acts. There are the following contrasts:[12] (1) Moralism is based on the belief that the individual can force himself to go in any direction he wants, whereas psychoanalysis finds that the self is not really free if it has to be forced by conscientious effort. In other words, moralism demands the internalization of authoritarian standards, while psychoanalysis demands a responsible judgment of one's own. (2) Moralism generalizes about free will, whereas psychoanalysis leads to the idea that people vary in the amount they possess and the degree of harmony upon which it is based. Moreover, according to psychology, the road to freedom lies not in putting on pressure but in expansion of self-acquaintance. (3) Moralism rests upon an atomistic view of the self, and does not recognize, as does psychology, the degree to which family tensions and cultural influences determine behavior. In other words, moralism neglects the communal aspect of evil.

There are five points at which there is a parallel between the Pauline-Augustinian doctrine of original sin and the psychoanalytic conception of neurosis: (1) Inner conflict—envy, mistrust. (2) The basic condition is enslaving—sins or symptoms are peripheral. (3) Instances of the injurious influences of others are seen to be so interwoven with personal reactions that it is difficult to differentiate. (4) It is almost impossible to determine the ways man has fallen into sin or neurosis by necessity or through his own fault. (5) The central problem cannot be solved by effort of will, but by change of the will itself.[13]

Both religion and psychotherapy insist upon this bondage of the will in addition to the cultural explanations of moral evil which are: (1) Social theory—the individual is the innocent victim of enslaving social maladjustments. (2) Evolutionary lag—man gradually making rational principles dominate over animal impulses, a slow process as he struggles upward from evolutionary origins. (3) Moral evil due to ignorance—this will largely disappear when man has adequate scientific understanding and control in connection with psychological and sociological phenomena.[14]

There seems to be a profound difference between Roberts and Tillich as to how sin and sickness should be correlated beyond this more or less obvious awareness of a similar problem of description. The clue to this difference lies, I think, in the fact that Tillich would like to incorporate the findings of psychology into the doctrines of Christianity, whereas Rob-

[12]The following discussion is based upon Roberts, *op. cit.*
[13]*Ibid.*
[14]*Ibid.*

erts would like to revise the doctrines so that Christianity's description of man's nature and predicament will be based on sound psychology. In order to understand the difference between these writers, let us examine some of their statements concerning man's predicament and more especially about what can or cannot be done about it.

Tillich, while recognizing that the difference between health and illness is quantitative rather than qualitative, insists that there is a sharp distinction between existential or normal anxiety and pathological anxiety.[15] Like Kierkegaard, he sees existential anxiety as universal, unavoidable, inherent in man's very situation. It cannot be removed. Existential anxiety can be defined in terms of the three ways in which nonbeing threatens self-affirmation—(1) fate and death, (2) emptiness and meaninglessness, (3) guilt and condemnation. The three are interwoven and all cause despair. Human life thus can be seen as the attempt to avoid despair. It is only when we fail to accept these uncertainties that pathological anxiety appears. The reason psychology has failed to discover the basic cause of pathological anxiety is that in elevating certain aspects, such as the will-to-power or the sexual drive to the place of primary importance, it makes no distinction between existential and pathological anxiety. "Courage cannot remove anxiety. Since anxiety is existential it cannot be removed."[16] The only healthy way to deal with existential anxiety, the anxiety of nonbeing, is to take it into and upon oneself. If the individual is not successful in doing this, he can avoid despair only through neurosis. Neurosis is "the way of avoiding nonbeing by avoiding being." It is the affirmation of a reduced self. Perhaps the most revealing statement in this description is that "Anxiety turns us toward courage because there is no alternative except despair."[17]

I should like to make two comments concerning Tillich's presentation. First, it seems to me that, in including guilt and condemnation in the category of normal anxiety, he is attempting to retain a rather dubious aspect of the doctrine of original sin—the necessity of feeling guilty about that which we cannot help. Second, without making any judgment as to which is correct, it should be pointed out that there is a contrast between Tillich's presentation and that of Horney on the matter of what, if anything, can be said to apply to mankind regardless of culture. Horney, whose work was used in our definition of neurosis, seems to feel that no statement can be made about human nature which does not have to be culturally qualified. Tillich, on the other hand, speaks of an existential anxiety, a universal tragic destiny. The real difficulty, I think, comes again on the question of guilt.

Roberts too locates the source of man's difficulties in his very free-

[15]P. Tillich, *The Courage to Be,* Yale University Press, New Haven, 1952, Chap. 2, pp. 32-63.
[16]*Ibid.*
[17]*Ibid.*

dom and intelligence. However, certain aspects of the doctrine of sin need to be corrected in the light of psychotherapy. Man's longing to exercise his creative powers should not be regarded necessarily as an indication of pride. "A paralyzing conflict between arid virtue and wayward vitality should not be regarded as part and parcel of what it means to be limited and creaturely."[18] In other words, the doctrine of sin should not condemn as an effort to "save himself" what is indispensable to man's "being himself." While Tillich tends to see everything from the point of view of the church judging the world, Roberts reminds us that the "regrettable alienation of modern culture from Christianity" is a reaction against the theological shackles it had to throw off in order to progress in enlightenment and self-understanding. The church has often labeled "sinful" resources which were potentially creative. Thus the doctrine of sin should be expanded to include and define more accurately the factors in human nature which can be used by God in overcoming sin. The value of the doctrine should be that it describes man's situation accurately and makes man aware of the seriousness of that situation. Psychotherapy does not paint a rosy picture of the unconscious when it shows man caught between libidinal drives and the restrictions of civilization. However, if psychotherapy has widened our concept of sin, it has also widened our ideas of how this bondage can be overcome.

There are four principles of psychotherapy which can help us to reach a sound doctrine of sin, free of harmful encumbrances: (1) Evasion of responsibility aggravates problems or delays the solution. (2) Full awareness of personal limitations, and contrition for those alterable, are preconditions for moral improvement. (3) The social ramifications of evil run beyond what the individual can control and violate his conceptions of what life should be; acceptance is not simple acceptance. (4) When sin is faced in a personal relationship of trust, man may be enabled to "do something" (by a method which is the reverse of moralistic effort) about problems he was previously impotent to solve.[19]

The following quote will serve to summarize Roberts' position:

> The doctrine of sin may rightly call attention to the fact that often men are not as free as they think they are. It may rightly hold that inner conflict which is a major source of moral blindness and ineffectuality cannot be overcome merely by an effort of the will. But there is nothing to be said for it, and everything to be said against it insofar as it instills or increases feelings of guilt for something we cannot help.[20]

The question of guilt then is a major problem in the relationship between sin and sickness. Both religion and psychotherapy are aware of the importance of guilt, but some writers[21] see the greatest difference between

[18]Roberts, *op. cit.*, Chap. IV.
[19]*Ibid.*
[20]*Ibid.*, p. 112.
[21]Such as A. Koberle, "The Problem of Guilt," *Pastoral Psychology.*

the two at this point. Religion can go along with psychotherapy concerning the importance of recognizing and facing the reality of evil in the depths of the soul. What disturbs theologians is the conviction of some psychotherapists that this dark element is potentially productive, not ultimately destructive. There would seem to be a difference too between the psychotherapeutic way and the Christian way of dealing with guilt. The assumption of Christian confession and absolution is that only God can remove guilt, whereas psychotherapy finds the answer in the reliving and transformation of painful experiences. It would be well, I think, to keep two points in mind here: (1) the distinctions that have already been made between genuine guilt and neurotic guilt, and (2) the question as to whether it is the very nature of man to feel guilty because of his fundamental predicament, or whether genuine guilt refers only to specific sins culturally defined.

The possibility of a constructive element in genuine guilt involves us in a second major problem of the relationship between sin and sickness—how to deal with the problem. On this issue Roberts mentions two possibilities for error.[22] The first is to underestimate, or fail to implement, the resources of health and recovery which are actually available. It is disastrous to regard anything as insoluble merely because of a doctrine of intrinsic wickedness. Being aware of the seriousness of man's predicament should be a challenge, and psychotherapy increases man's ability to solve his own problems. Theology deserves criticism where it equates goodness with slavish dependence upon an arbitrary tyrant God, and where it represents God as wanting a submission which would exclude man from participation in his own improvement or salvation.

The second possibility for error lies in exaggerating the extent to which man can solve the problem of evil "on his own." Knowledge of the resources in man can easily lead to the worship of man's self-sufficiency. The strongest theological argument is that human possibilities are grounded in God. We have the right to reject theology which ignores or belittles man's participation, but man does not create the resources on which he draws.

Other writers[23] feel that this problem of treatment is definitely a point of incompatibility between psychotherapy and religion, because psychotherapy in general believes that the power to overcome neurotic problems lies within man himself, that he does not need to turn to God. For psychotherapy a Godhead, authoritarian or otherwise, is not necessary for dealing with meaninglessness; all that is necessary is a commitment to all of living.

For the Christian there certainly can be no question as to the necessity

[22]Roberts, *op. cit.*
[23]G. B. Blaine, "Religion and Psychiatry: Some Philosophical Observations," *Journal of Pastoral Care,* XI (1957), No. 2; and L. Salzman, "Observations on Dr. Tillich's Views on Guilt, Sin, and Reconciliation," *Journal of Pastoral Care,* XI (1957), 14-19.

of God. But I do not see why this decision, which is a matter of faith, should be considered incompatible with psychotherapy. The mainstream of Christianity has always been vitally concerned with the physical health of human beings, but it certainly has not insisted that ministers must be medical doctors. It has rightly assumed that God has given and works through medical knowledge. Moreover, it has long been known that the power necessary for healing lies not only in the drugs and skill of the doctor but within the body of the patient himself. Why is it so difficult for us to see that these same principles apply to psychotherapy? From the Christian point of view God works through both the analyst and the resources within the patient. Let us say that where there is an act of love there is God, whether the human instrument is aware of it or not. Perhaps the most important contribution of psychotherapy in connection with treatment is the insistence that if we are to help a person we must enter into a personal relationship with him and actually bear the other's burdens. To the Christian this cannot help but sound familiar.

In order to draw any conclusions we must decide whether or not we are going to call our existential, unavoidable limitations sin. I would have to agree with Hudson and Roberts that "If there is necessity there is no sin." If this is our decision, it follows that we should not feel guilt merely because of limitations we cannot help; to the extent that we do feel such guilt it is neurotic and not genuine. Genuine guilt would be connected with a specific sin and would have a constructive element within it. It should be remembered, however, that our actual knowledge of the intricacies of human nature does not permit us to apply this theory in any such clearcut way. It is difficult if not impossible to determine just where necessity ends and sinful action begins. It may be that all evil, destructive, sinful acts are due entirely to sickness, that every man sins because every man is to some extent driven by social and inner forces beyond his control. On the other hand, it may be that some persons commit evil acts not from necessity but simply because they want to. As our knowledge stands now we simply do not know.

# SOME REFLECTIONS ON THE FUTURE OF THE SUMMER QUARTER OF CLINICAL PASTORAL TRAINING

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It will not be my purpose in this brief paper to predict the direction in which clinical pastoral training will develop in our seminaries and institutions. Rather, I shall let the past and the present judge this enterprise and shall try to point to opportunities that are available for the future. I wish that I could say what I want to say more fully, but the limitations of this paper permit not much more than an outline presentation. It is my hope that the readers will be able to provide the illustrative material necessary to fill out this outline.

My wife went recently to a parent orientation program conducted by our school system, the purpose of which was to acquaint the parents with the intent and goals of the curriculum for each of the grades. In reference to the first grade, a supervisor for our school system said: "Our intent is to teach children who say, 'Look, teacher, I brung my lunch today,' to say instead, 'Look, teacher, I brought my lunch today.'" Our youngest child's first-grade teacher was sitting next to my wife when this was said, and she leaned over and whispered: "That's all right, but my life as a teacher would be so much less interesting if I couldn't hear what I did today. Tommy said to me just before lunchtime: 'Mrs. Burns, would you please cut the *hems* off my sandwich!'"

In clinical pastoral training it must be our concern both to correct the erroneous and to encourage and tolerate the inexact but creative growing edges. It must be our concern both to correct "brung" to "brought" and to tolerate "crusts" being called "hems," especially when the word "hems" symbolizes for the student a momentarily meaningful way in which to describe and account for an exciting new experience. I would like to speak about some of the corrections our past demands us to make, and also of some of the tensions or inexactnesses our present bids us to tolerate in the enterprise of clinical pastoral training in order that we may more realistically plan and shape our common future in this one phase of theological education. But before I proceed further, I wish to acknowledge the fact that a good deal of what I am about to say was sharpened up for me by my co-supervisor and our chaplain-residents now

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in advanced clinical training in the Council for Clinical Training accredited program at St. Luke's Episcopal Hospital in the Texas Medical Center. Also I want to make it clear that *what follows has specific reference only to the typical summer quarter of clinical pastoral training offered to seminary students for whom this will be their only clinical training experience.*

**What Needs Correcting?**

As important as anything else that needs correcting are the various confused notions as to what clinical pastoral training really is, and how it may be more clearly distinguished from other distinctive ways in which the theological student or ordained pastor is helped in his efforts to become more adequately prepared for the pastoral ministry. That these distinctions have remained unclear or become unclear is understandable because in some respects there are internal similarities betwen clinical pastoral training and these other disciplines.

One discipline with which clinical pastoral training often is confused is field work, itself a valuable and important educational method. But despite similarities at some points, basically these are different enterprises and as such should be clearly distinguished one from the other. In field work the emphasis is on performance, on what the student does in the hours in which he is in the field. Here pragmatic concerns are all important: How many people are being adequately cared for or helped? What are the ways in which helpful things can be done for and with the people served by the church or agency? What is the task to be performed and how best can it be performed? These are the pertinent questions a supervisor of field work must raise with the student. In clinical pastoral training, however, although tasks are performed which sometimes are very similar to those performed in field work, the focus of supervision is not on the task itself but rather on the *student in his task.* In clinical pastoral training the supervisor must *help the student* in the process of discovering the meaning of what he does, to him and to the person for whom he does it. For the moment of his clinical pastoral experience there is no holy ground—there are no basic assumptions which are uninvestigatable. Without a thoroughgoing inquiry into the student's (and, indeed, the Church's) basic assumptions there is no clinical pastoral training! But in field work such an inquiry is not only out of place, it is irrelevant. Another way of saying this is to say that the opportunity in field work is to give the "word" and to do the "deed." And when things are not going well, the student is bidden to give more of the word and to do more of the deed . . . or, perhaps, to give a different word and do a different deed. In clinical pastoral training the word does not count unless it becomes flesh, and effectiveness is measured solely in terms of the degree to which the word and the deed and the man functioning as pastor have become one.

Another discipline with which clinical pastoral training is sometimes

inappropriately confused is the discipline of psychotherapy. And I believe it is fair to point out that in some instances this confusion is shared by supervisor and theological faculty alike. I could make a lengthy personal confession at this point, but perhaps just one illustration will suffice. Over a period of years one seminary sent me different ones of its very troubled students. There was no pretense about the purpose involved. The faculty saw each of these students as a borderline candidate for the ministry because of his inadequate emotional adjustments, and clinical pastoral training was prescribed for him as a means of getting cheap psychotherapy. Even though I believe each of these men was helped some, none of them received clinical pastoral training. Clinical pastoral training is not psychotherapy, despite the fact that at some points an experience within clinical pastoral training will look and feel like a psychotherapeutic experience. I have already indicated above that clinical pastoral training differs from field work in that field work focuses on the performance of a task, while clinical pastoral training focuses on the *student in his task*. Using this as a base, we can differentiate between clinical pastoral training and psychotherapy by pointing out that the focus of psychotherapy is upon the person as a person—not in vacuum, but neither seen as necessarily being in a constant role whereas the focus of clinical pastoral training is nesecsarily upon the person in the constant role of the pastor. Or, to put this another way, the focus of psychotherapy is upon the person as subjective conditioner of the objective reality of which he is a part, whereas the focus of clinical pastoral training is upon the person *at the point at which* he subjectively conditions (or meets) objective reality.

One further source of confusion of clinical pastoral training with other dimensions of theological education is the lack of clarity that exists between clinical pastoral training and the academic curriculum of a theological school. One symbol of this confusion is the practice of some seminaries of offering academic credit for clinical pastoral training in amounts varying from four to twelve credit hours for a three-month period. I stand firmly against this practice. In an academic curriculum the necessity of necessities is an intellectually and scientifically respectable *body of knowledge*. In the aggressively creative faculty this body of knowledge is not seen as static "once and for all delivered unto the saints," but nonetheless at any given moment the faculty member responsible in a given field can lay his hand upon and communicate to his student or otherwise help his student discover that body of knowledge. Out of this posture academic grades can be given, right answers can be differentiated from wrong answers, preferred points of view can be delineated. Such is not the case in clinical pastoral training. Here it becomes the student's responsibility to discover and create his own body of knowledge specifically relevant to himself, and perhaps to himself alone. There is no "right" way or "wrong" way to offer pastoral care, there is only the best way for me or best way for you. And even though we may gather around ourselves a company of a half dozen, a dozen, or more fellow-travelers who

share with us our own "best way," this is no assurance that the next man who comes along will be able to share our way fully. When we speak of pastoral care being an "art," we mean that it cannot be separated from the personhood of him who offers it; we mean that each pastor becomes responsible for the creation or verification of his own body of clinical pastoral knowledge. A current occasion for concern in this regard is the growing practice of seminaries offering so-called courses in clinical pastoral training taught or supervised by members of their own faculties. However necessary or desirable this practice may be, a word of caution is in order. Unless great pains are taken to distinguish adequately between clinical pastoral training offered by a seminary and the more normative curriculum the seminary offers, both this curriculum and clinical pastoral training stand to suffer.

Implicit in what I have said above about the demands our past makes upon us to correct our unclear understanding of clinical pastoral training are certain tensions and inexactnesses our present bids us both to encourage and to tolerate. Let us now consider some of these.

As regards the relationship between clinical pastoral training and field work two such tensions can be mentioned: First, if we really accept the premise that in clinical pastoral training the focus of supervision is not upon the performance of the task but rather on discovering the meaning of this performance to both the person of the pastor and the person of the parishioner, then obviously many tasks are going to be left undone, and others are going to be less well done than is desirable. People are going to be left uncalled on, instruction or work groups may lose members, devotional materials may not be distributed, prayers may be left unsaid. Is our evaluation of clinical pastoral training positive enough to enable us to tolerate this? Secondly, the more the seminaries come to accept the conclusions of the Niebuhr studies on theological education, the more the advocates of both clinical pastoral training and field work are going to have to stand together pleading what may appear to be a common cause. Can those of us who are supervising clinical pastoral training tolerate this inexactness?

In considering the proximity of clinical pastoral training to psychotherapy one constant difficulty confronts the supervisor. He, by virtue of his training and experience, is nearly always aware of areas of the student's needs of which the student himself is either unaware or for which he is not yet ready to seek help; and indeed there will be many of these areas of need (as pointed out above) that the limitations of the clinical pastoral training context render inaccessible. Whatever balance he arrives at between his concern for the personhood of the student on the one hand and the discharging of his appointed task as a minister and supervisor on the other, the supervisor of clinical pastoral training who has the degree of sensitivity we expect him to have will yearn to help the student in ways more appropriate to the discipline of psychotherapy than

his own. Can he and the seminaries tolerate the tensions which the inexactness of clinical pastoral training's posture creates?

The tensions growing out of the diversity in origin of the body of knowledge appropriate to the academic discipline and the body of knowledge appropriate to the clinical center are familiar to us all. The student comes from the seminary into the clinical center raising for the supervisor questions reflecting the precision of the academic body of knowledge, and the student returns from the clinical center to the seminary raising for the professor questions reflecting his newly created body of knowledge born out of his recent encounter with persons in crisis. Can we continue to encourage this kind of mutual confrontation and tolerate the temporary inexactness that is bound to result?

The answer we give to the questions raised above will, I believe, shape the future of clinical pastoral training.

# RELIGIOUS EXPERIENCE AND PSYCHOLOGICAL CONFLICT

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I shall center my attention upon the constructive aspects of the profounder variety of psychological conflict to which we give the name of "schizophrenia." I shall submit and defend the proposition that psychological conflict, even in its schizophrenic manifestations, has religious significance. It is due to the operations of conscience and is the price we pay for being men and having the power of choice and the capacity for growth.

The price is indeed a heavy one. No one who deals with mental patients can fail to recognize that fact. What we see in many of our patients is adaptations to defeat and failure which have been made and accepted. There are reactions of escape, of self-deception, of delusional defense building. No one can call such reactions constructive. They result in social isolation. In many cases they result in progressive disintegration of the personality. And insofar as there is no fighting spirit, no will to get well, the outlook for recovery is poor. In such cases the end is likely to be destruction.

But there are forms of mental illness which are manifestations of healing power analogous to fever or inflammation of the body. These are the forms of mental disorder in which, as chaplain in a mental hospital, I have been especially interested. It is to these that I ask your attention. They are periods in the development of the personality in which the individual feels himself face to face with ultimate Reality, periods in which fate hangs in the balance and destiny is in large measure determined. In such periods religious concern is much in evidence and the creative forces are exceptionally active. So also are the forces of destruction. They are periods of seething emotion which tend either to make or break. As such they are closely related to the dramatic conversion experience which has been so prominent in the history of the Christian church since the days of Saul of Tarsus.

Here is such a case. The patient in question was a man of 38 years who was brought to the hospital in a severely agitated condition. He thought he had committed the unpardonable sin and that something terrible was going to happen to his wife and children. He would not, therefore, let

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them out of his sight. He thought a world war was impending; and, when asked what part he was to have in this war, he replied: "A little child shall lead them." Obviously, he was the little child.

The record of his life was that of a well-meaning, friendly, likeable person who before his marriage, and even afterward, had been sexually promiscuous. What troubled him most was an affair with a woman some ten years older than himself, clearly a mother-substitute. There had been two abortions, for which he was responsible. She had died of carcinoma. He blamed himself for her death, and the disturbance began shortly thereafter.

The first symptom was heavy drinking. This continued, until he lost his job. Following this, he suffered a depression and stopped drinking. Then he developed the idea that the Odd Fellows were out to get him because he had violated the oath he took when he joined them. For several months he was obsessed with ideas of persecution. He reached the point where he went to the police with a request for a permit to carry a gun in order to protect himself from his enemies. He became finally so disturbed that he confessed to his wife, telling her of his sexual transgressions.

This confession she took in good spirit, but in spite of that fact he became more and more agitated. The idea came that something was going to happen to her and that he had to carry the weight of the world on his small shoulders. Commitment then became necessary.

In the hospital he showed intense anxiety. He was sure of only one thing: that things were not what they seemed. He was also deeply aroused religiously. It is not necessary for our purpose to recount his subsequent history beyond reporting that within a couple of months he made an excellent recovery and now, after nearly 30 years, there has been no further trouble. He is at present a successful contractor, and his family is prosperous and happy.

Here, then, is an acute crisis experience, the culmination of a severe inner conflict. In intensity it reached the point of psychosis, but the outcome was constructive. It may thus be looked upon as a problem-solving experience which had genuine religious value, and it exemplifies the type of experience with which I am here concerned.

Notice in the first place that this man had reason to worry. Although outwardly successful and well liked, he had made a mess of his relations with significant persons in his life—a woman who had been for him a mother-substitute, the woman he had married, and two unborn children whose lives he had helped to snuff out. The fact that he was a well-meaning, socially sensitive person, brought up in the Protestant Christian tradition, caused this disloyalty to weigh heavily upon him, especially following the death of his mistress. It may be said that he felt

himself recreant in all his biologically significant relationships—as son, as husband, and as father.

Notice, furthermore, that the devices he employed in attempting to deal with the resulting sense of failure and guilt were at first of the definitely malignant type. He sought relief in strong drink. He tried to forget, to escape. This meant a way of life which usually terminates in progressive disintegration. Fortunately, however, the loss of a job brought him to his senses, and he gave up drinking. But the uneasy conscience from which he had been fleeing came back at him in the form of accusing voices and persecutory ideas. The Odd Fellows were after him. Enemies were out to destroy him. He finally became so uneasy that he went to the police, seeking permission to carry a gun. When the permit was refused, he became desperate.

His next step was in the right direction. Instead of trying to forget and to repress, he went to his wife and confessed his transgressions; and the wife took the confession in good part. Inasmuch as confession and forgiveness are of the very essence of psychotherapy, we might expect that he would now find peace of mind. But such was not the case. Instead, he became increasingly agitated and developed all sorts of irrational ideas. He was doomed to die. His wife and children were in danger. A great war was impending in which he was to have an important part. He became so deranged that there was no alternative but commitment.

Why now the increased agitation following the confession to his wife? Such a question is in order. The answer is clear. The emotional disturbance was not the result but the *precondition* of the confession. In his normal state of mind confession would have been impossible. But the profound emotion forced the confession, just as nature's healing power produces a boil or an abscess and then lets the poison matter out. In this case, as in others of the type, the disturbance brought about a certain degree of socialization. It got rid of pretense and hypocrisy and put the sufferer in position to be accepted for what he really was. And if it took some time for the powerful emotion to subside, that is hardly to be wondered at.

This case I present as an example of severe mental disorder in its more constructive manifestations. It is, of course, not often that we find the outcome of a schizophrenic episode so definitely favorable or its distinctive features so clearly apparent. But such experiments of nature serve to throw light upon cases in which the dynamic factors are not so clear. Studies of my own indicate that at least one in ten of our newly admitted schizophrenics are clearly of the acute type. Harry Stack Sullivan used to insist that an acute, anxiety-laden phase would be found in the onset of most cases of schizophrenia, if only our information were adequate.

What now can we learn from this case and from the group it represents regarding the interrelationship of religious experience and psycho-

logical conflict? The answer derived from the studies which I have made may be summed up as follows:

1. Functional mental disorder is best understood as an attempt to deal with an intolerable sense of personal failure and guilt. This attempt may take a number of forms, three of which are included under the concept of "schizophrenia": (*a*) drifting, withdrawal, throwing in the sponge; (*b*) delusional defense building, transfer of blame; (*c*) desperate attempt at reorganization.

2. Of these three reactions, the first is characterized by absence of religious concern and a tendency toward progressive disintegration; the second, by deviant religious concern and a tendency toward stabilization on an unsatisfactory basis; the third, by enormously accentuated religious concern and a relatively high recovery rate.

3. Schizophrenic episodes are likely to begin with intense preoccupation regarding one's own role. Such states of mind are favorable to creativity but not to balanced judgment. Strange ideas come surging in so vividly that they may be ascribed to a superhuman source. Ideas of death, of world disaster, of cosmic identification, and of previous incarnation together with a sense of urgency and mission form a constellation which is pathognomonic of the severer cases.

4. Other things being equal, the outcome of an acute schizophrenic episode is likely to be constructive insofar as it represents an honest attempt on the part of the patient to grapple with his real difficulties. It is likely to be unfavorable insofar as it is associated with the reactions of wishful thinking, concealment, and transfer of blame.

5. Cases similar to the one presented form a continuum with those of certain men of outstanding religious genius who also have passed through searching experiences which have had definite schizophrenic features. Among these we may think of George Fox, Emmanuel Swedenborg, Saul of Tarsus, and the prophets Jeremiah and Ezekiel.

6. In order to understand either mental disorder or religious experience, the one should be studied in the light of the other.

# CONSCIENCE, GUILT, AND THE UNWED MOTHER

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Almost fifteen years ago the two volumes by Dr. Helene Deutsch on the psychology of women were published.[1] In those 900 pages she said many valuable things, including a great deal about the psychology of motherhood and considerable about the psychology of unmarried mothers. Since that time not very much that is entirely new or as penetrating has been published about these subjects. To discuss either of these topics usefully could hardly be done better than by summarizing what she has said; however, even such a summary would be long, and many of you, I know, have already thoroughly read Helene Deutsch.

We shall focus our attention on one or two aspects of these many-sided subjects and in that way possibly see a little more deeply into some part of the psychology that it is useful for many of us to be familiar with, in working with the girls who come to Florence Crittenton Homes. I say "useful for many of us" rather than "for all of us" to be familiar with because we know of individuals who, without formal training in psychology, intuitively sense what is needed in a particular situation and supply it. What is more often than not referred to in a jocular vein as "woman's intuition" is actually a universal recognition of a biological and psychological fact that many women, and probably only women, possess, a capacity for sensing what is taking place within a child or a young person. In recognizing this intuitive capacity we are already looking at a specific facet of feminine psychology which has probably developed through the centuries as a necessary part of motherhood. These women will continue to do as well or better in dealing with many of the difficult problems that accompany the unwed mother into her place of confinement than those of us who are intellectually familiar with the "dynamics" of human behavior.

But not everyone is equipped with the same degree of intuition; hence for many of us an acquired understanding of the anatomy of personality and its functions is necessary.

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Paper delivered at the national meeting of Florence Crittenton Homes in Washington, D. C.

[1]Helene Deutsch, *The Psychology of Women,* 2 vols., Grune and Stratton, 1944-45.

Helene Deutsch used the term "motherhood" in this way:

> Motherhood refers to the relationship of the mother to her child as a sociologic, physiologic and emotional whole. This relationship begins with the conception of the child and extends throughout the further physiologic processes of pregnancy, birth, feeding and care. All these functions are accompanied by emotional reactions that are to some extent typical of, or common to, the species but for the most part vary individually, for they are inseparably connected, in each woman, with the total personality.

It is the last point that I want to emphasize—namely, that the emotional reactions accompanying the pregnancies of the unwed mother are connected inseparably with her total personality. It becomes impossible to explain the emotional picture with which we are confronted without taking into account all of the parts of the personality, most of which have regular functions quite apart from motherhood. In fact, some aspects of the feminine emotional picture that are especially confined to the experience of motherhood are not often present in the period of our observation of a Florence Crittenton mother. I have in mind, for example, some aspects of "motherliness" that are developed or brought out only over an extended period of exposure to a growing child's dependence. Another way of looking at this last point is that the total psychology of motherhood includes a broader set of phenomena than one usually deals with when working with a Florence Crittenton mother. In fact, one might make the generalization that an understanding of the psychology of the adolescent girl is of even greater importance. Obviously, the psychology of the adolescent girl and the psychology of motherhood are not unrelated to each other; they overlap in many respects. But my point is that many if not most of the pictures and problems presented by the unwed mothers are reflections of struggles of adolescence rather than of mature motherhood.

Since I have suggested that we narrow our field of study so that we can go a little deeper than surface psychology, we might do well in selecting the emotion of guilt, and look at some things about its origins and its functions (both normal and abnormal) in the unwed mothers that we are able to study. In doing so we are choosing a subject that is important both to adolescence and to motherhood. When intuition fails or is not available, a theoretical knowledge of some of the various possibilities of the role of guilt may prove of particular importance in enabling us to serve in the most useful way.

The part of the mind that concerns itself with the production of guilt, including guilt about which an individual may be entirely unaware (that is, unconscious guilt), is of course the conscience. If we were to be more technically accurate we might say the super-ego. We are aware that the conscience can reward as well as punish.

Were we to select a girl at the Florence Crittenton Home with a

normal conscience, and we can certainly find such individuals, we could make certain reasonable assumptions. We know from experience, that is from the experience provided by the field of psychoanalysis, that her conscience underwent its crucial stage of development (not its final stage) when she was around four to six years of age. Prior to that time, in order to feel badly because she had done something that was forbidden by her mother, her mother or mother substitute would personally have to criticize or scold her. After that time she could feel badly about having been naughty even though she were all by herself. What brought about this difference was that at that time in her life this little girl had developed a capacity to make over a portion of her mind (technically a portion of her ego) into an image of her most important authority or authorities (usually her mother or both parents). She was able to do this by means of a special form of identification with that authority. From then on throughout the rest of her life, including adolescence and motherhood, this internalized image had to be reckoned with.

In later years, regardless of the culture in which she finds herself and irrespective of the intellectual attitude she may develop concerning right or wrong, this early-formed part of her mind will try to have its say. It will try to say it, try to punish or approve behavior in much the same way as it did in the beginning. Always there are added to the inner "voice" of this early authority the attitudes or expectations of later authorities or respected figures, such as teachers, religious figures, heroes, and eventually society. Although these later authorities become part of the conscience and are necessary in bringing about a final mature conscience, probably in adolescence, it is important to remember that the basic internal judge or mental censor that must be dealt with is the early image that was given such a special place and role in the growing mind. Thus we can see that, no matter how uncritical and benevolent a social environment we might theoretically provide for an unwed mother, in the last analysis the character of this original basic conscience will determine the amount of guilt with which she has to deal. Sometimes it happens that the demands of a particularly harsh conscience are softened through a relationship with an individual who is loved or greatly respected and who provides, as it were, "on loan" a less severe conscience which she can use for a period of time. If this relationship is disrupted the old conscience reasserts itself with little change.

If we look further at our unwed mother with a normal conscience we might find typically that she does become aware of feelings of guilt and shame about her sexual transgression but these do not become overwhelming or chronically prolonged.

Because of the real sacrifices involved, such as giving her child up for adoption, a considerable part of the normal demands for punishment on the part of her conscience are "paid for," and the pain of having to put off until later the developing joys of motherhood replaces what other-

wise would have to be more punishment on the part of her conscience in the form of feelings of guilt. Just as her sexual transgression demands a resolution so does the aggressive transgression (as far as her conscience is concerned) of abandoning her child. Here also for the girl with a normal conscience the suffering involved with the sacrifice and loss of her child tends to supply the amount of penance (or reparation) demanded by her conscience. Ideally this resolution of guilt through suffering is a conscious process. Whenever a girl tends to deny what has taken place, for example with the assistance of choosing never to see her baby, this debt to her conscience and its payment may have become an unconscious struggle. The mind then in often prolonged and indirect ways may later attempt to appease this now buried or hidden debt. This usually takes the form of seeking or provoking punishing experiences that superficially may appear unrelated to the occurrence of the illegitimate pregnancy. Helene Deutsch reminds us that this unconscious need for punishment may sometimes be the primary motive for repeating the whole thing by means of a second illegitimate pregnancy.

With regard to the girls who have pathological conscience structures or structures with faulty development two general types can be indicated: those with an underdeveloped conscience and those with an exaggerated conscience. There are several ways in which a deficient conscience can come about. The most typical defective or weak conscience occurs when the early figure of authority offers the little girl so few prohibitions, is so overly permissive, that as the internal image of that authoritative figure is formed there is a very ineffectual source of inner guidance available to deal with her sexual or aggressive impulses as they occur. Related to this is the case in which, although prohibitions occur, the authority—say the mother—has so little control of her own behavior that the little girl's identification with her interferes with her normal conscious functioning—that is, she does as her mother does, not as she says.

Another common origin of defects in the structure of the conscience is a poor relationship with the early authoritative figure. There can be a number of reasons for this—for instance, the absence, because of death or separation, of a suitable figure to internalize, combined with many changes from one mother or parental figure to another. In such a case a stable image may have no opportunity to form in a child's mind. Another form of the inadequate relationships may be that in which there is an authoritative figure but so much hatred develops for this figure that the little girl needs to reject any identification with that person. Here the conscience may form and in fact be very exacting but, because of the hostility, expectations from the conscience are consciously rejected and become useless. This we often see in the rebellious girl. This picture usually is more understandable as we remember that, although consciously such a girl's conscience may be ineffectual, underneath unconsciously it is still demanding its due. The

particularly destructive nature of the rebellious activity usually replaces conscious guilt.

One other circumstance in which a poor relationship results in a poor conscience is one in which the authoritative figure herself or himself sexually seduces the little girl. This usually eliminates almost entirely any subsequent support from the conscience in this area; however, it is surprising how often the ego attempts and sometimes succeeds in repairing this difficulty by making use of a subsequent authoritative figure who loves more wisely.

The third and last type of deficient conscience structure is seen at times in the psychotic girls who come to us. There, if the illness has been present since very early childhood, there may never have formed a good conscience because of the little girl's inability to relate sufficiently well to anyone strongly enough to form the required internal mental figure (that is, to form an adequate object-relationship). Failure to recognize or to remember this possibility has unfortunately resulted at times in some parents being unjustly blamed for their child's uncontrolled behavior. When a psychosis waits until later than childhood to affect behavior, the weak or absent conscience that occurs at that time may be only a part of a disturbance that has disrupted the function of the entire mind.

It has often been gratifying, but never surprising, to me, to see the number of ways in which, through the relationship with their worker, girls with conscience deficiencies of the first groups have been helped. But what at first was surprising (less so now as I see it repeated) was to observe the regaining of control impulses in a frankly psychotic girl coming into the Home with a very recent history of clearly disorganized and uncontrolled behavior who could not relate to her worker. What the explanation is in these instances is not always clear. Very likely it is that the obvious qualities of the Home itself provide an immediate therapeutic atmosphere and in the presence of this security the psychosis is lessened to such a degree that as ego functions improve, conscience functions return.

Finally we may look at the second general type of pathological conscience, that of the exaggerated or cruel and sadistic super-ego. As one might predict, these are not seen as often as the others because such a girl is less apt to find sexual impulses out of control, or, in fact, find herself in the situation where there is any such risk. However, this does show itself to us at times and is often an important factor in the depressive reactions that have to be dealt with. Girls who come to Florence Crittenton Homes exhibiting obsessive compulsive symptoms have an extremely cruel conscience. It can be useful and sometimes crucial to remember, when seeing a girl who exhibits obsessive-compulsive characteristics such as exaggerated conscientiousness about assigned tasks, extreme concern about cleanliness or particular rigidity or stubbornness (about her points of view, for example)—that these invariably are her defenses against the

exceedingly cruel underlying conscience and that, if these characteristics were to be rapidly taken away or interfered with, a depressive reaction might very well break through. The origins of such an exaggerated, sadistic conscience are usually complex but let us consider some of the aspects. We might remember that the unwed mother with the obsessional type of conscience is not that way because of a very strict early authoritative figure. For this reason it should not be surprising if she is not as subject to change by identifying with the healthy conscience of her worker as some of the girls with other kinds of abnormal super-egos. This girl's conscience is not acting in imitation of a cruel parent (although she often may believe this is the explanation). Her conscience has undergone a distortion because of a mental characteristic that we know as regression; that is, at the time of the formation of her conscience she had for various reasons (usually not harshness of parents) had to abandon the interests and perspectives of a four-to-six-year-old little girl and return to looking in some ways at life much as she did when she was two or three years of age. Since we know that a little child usually interprets the feelings of those around her largely in the light of her own feelings, and if we remember that the hostile, angry reactions of a two- or three-year-old are of greater intensity than those of a normal four- or five-year-old, then it follows that when she thinks of the authorities around her as being cross, angry, or forbidding they appear much more so than they are likely to be in reality. At least the picture of authority that is internalized undergoes regressive changes and often becomes that of a cruel slave driver which exploits and exaggerates her natural feminine capacities to endure suffering to such an extent that she always has to choose suffering and avoid anything appearing normally pleasurable. I spoke of the relationship of this severely obsessional type of conscience to the depressions we see at times among the girls—I think we can also see from what has been said that understanding the very masochistic girl would involve knowing about this from repressed conscience.

To say that such a cruel conscience is not the result of harshly strict parents is not to say that there aren't harsh parents; but rarely are they as cruel as the aggressive impulses of a two- or three-year-old child. It is these latter impulses that are the stuff of which an obsessive-compulsive girl's conscience is made.

We might keep in mind something that Mary Louise Allen pointed out in her recent article in *Coronet Magazine,* i.e., that a significant portion of unwed mothers come from middle-class environments. This makes the possibility of educative measures seem likely. If some of the influences of conscience formation in its crucial period are beter understood by a parent, the chances of reducing certain types of illegitimacy might be improved.

The subject of every child's development around the years of four to six leads into areas of thought to which the average parents are highly

sensitive. It is difficult to accept the fact that a little girl of this age is confronted with the kinds of impulses and longings with which she must struggle later in adolescence. Once this fact is grasped, however, a parent may be better equipped to judge some of the measures that may be helpful to the child in her mastering of this period of development.

Every child at this age typically develops wishes to possess—exclusively—in a loving way one or the other of the parents. This of course involves an aggressive wish to eliminate the other parent as a rival. These wishes may vacillate from one parent to the other with an intensity of feelings that is very similar to that observed in sibling rivalry. What the child's task is at this time is to confront the fact that she will always be regarded by these parents as their child and she will not grow up and replace one or the other of the parents. Depending on the extent that the little girl can accept the fact that her daddy will always belong with her mother and that she will have to wait and eventually seek another man for her own, she will then feel more at ease with her mother. This enables her to identify with her mother in a helpful way and her conscience formation is then a healthier one. If she remains attached to her father in an exaggerated way, her mother appears exaggeratedly punishing to her and her conscience is in danger of being correspondingly cruel and guilt ridden.

This allows us to see how important a good relationship between the parents can be in helping a child master this ordinarily trying period and in forming out of it a firm but not guilt-ridden conscience.

When a child for any reason is excluded from one parent's love or where excessive measures tend to attach the child to one parent—such as spoiling or conspicuous favoritism or overstimulation of a physical sort—these things tend to make it more difficult to give up the typical longing and fantasies for exclusive possession that characterize this crucial period. That these fantasies of and longings for exclusive possession, if they are not given up at this earlier age, become unconscious, only to give trouble later in adolescence where again strong aggressive and sexual feelings and yearnings arise, is a situation with which those of you who work daily with Florence Crittenton girls are often confronted. However, that is another related area of personality development, and our purpose has been to confine our area of study to only a portion of the psychology of women, that of some of the forms that the conscience takes and some aspects of their origin.

# TWO DOCUMENTS ON THE CHAPLAIN'S RELATIONSHIPS

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## I. The Chaplain's Relationship to Church, Churches, Institution[1]

Like that of Gilbert and Sullivan's policeman, the chaplain's "lot" can occasionally be a "hard one." Not the least of his difficulties is the task of dealing with complicated responsibilities to his own church body, to the interfaith agency responsible for chaplaincy service in public institutions, and to the institution or agency in which he serves. Likewise, he often must deal with the similarly complicated business of enlisting support for religious services from these diverse sources in ways appropriate to each of them. In addition, within the institution there is persistent daily pressure to clarify the nature of the chaplain's role. These brief notes report on the experience of one state Council of Churches' committee in arriving at some degree of explicit self-understanding.

*Local Background: The Churches and the Institutions.* In 1949 the people of Kansas were shocked by a series of legislative and newspaper exposés of their public welfare institutions. Conspicuously noted in this period of painful self-discovery was the fact that Kansas was forty-fifth among the states in expenditures per patient per day. A wave of popular concern was directed by Governor Frank Carlson (now U. S. Senator) into a special study committee. This committee's recommendations focused attention on staff training and accreditation of institutions for further training. A familiar slogan was "brains not bricks" and, in keeping with the spirit of the slogan, extensive plans were made and appropriations approved for personnel development, at the immediate expense of any building program. These plans focused at Topeka but included two other state hospitals, an epileptic hospital, two tuberculosis sanitaria, two training schools for adolescent delinquents, and a children's receiving institution.

Early news releases mentioned the inclusion of full-time chaplaincy service to patients. These plans were made out of concern for adequate patient care but without any previous consideration of ways, means, or problems. Chaplain Robert A. Preston, then of Winter Veterans Administration Hospital, Topeka, and the Rev. Milton Vogel, executive secretary

*At time of writing Chaplain-Supervisor at Topeka State Hospital.
[1]Report to the Committee on Chaplains, Kansas Council of Churches, May, 1957.

of the Kansas Council of Churches, immediately recognized the opportunity and the danger. They congratulated the state for its concern and offered the services of the state Council of Churches in selecting as nominees for chaplaincy positions clergymen with adequate training and generally acceptable to the Protestant church bodies. This offer preceded, by only a few hours, the first wave of a small deluge of applications for chaplaincy positions. The variety in these applicants was, to put it succinctly, wide. To escape from this deluge the state Board of Social Welfare and the Kansas Council of Churches exchanged a "Memorandum of Understanding." Its first and most welcome effect was to provide freedom for public officials from the necessity of evaluating the merits of clergymen in the exercise of their religious functions. The memorandum—so called because it simply stated proposed practice rather than firm official policy—noted the common concern for the spiritual needs of patients and inmates. It proposed that, while the "sole source of nominations" for chaplaincy appointments would be the Kansas Council of Churches, such appointments would be made by the legal-qualified appointive officer in each institution under provisions of job specifications to be approved by the state Civil Service Board.

Thus nomination was reserved to the churches; hiring, appointment, and support were reserved to the state. Employment meant the chaplain was subject to and protected by the varied provisions of the state merit system. At every point in the arrangements the chaplain was assured official (with pay) leave sufficient to "maintain his ecclesiastical connections." Further, this division of powers meant that the official civil service specifications for employment need not be burdened by requirements of clinical training—impossible because clinical training, unlike the internship of the physician, or the hair-cutting proficiency of the barber, has no place in Kansas statutes, or before state-approved licensing agencies. However, such training could be listed in the specifications as "desirable preparation for work" and it could be enforced or examined by the chaplaincy committee of the Council of Churches, as pre-requisite for *nomination*. Merit examinations for chaplaincy positions were offered as "unassembled" examinations —i.e., they asked only for listing of educational and professional experience with supporting transcripts.

A final note concerns itself with the disciplined restraint of the church council committee from using political pressure to secure the opening of chaplaincy service in previously unserved institutions. In every case, the addition of a full-time trained chaplain to the staff of an institution has been delayed until the "climate" of clinical practice led to a request for such service from the staff of the institution. (Needless to say, there have been a few institutions in which this "climate" was precipitated only by some enlightened "cloud-seeding," but, at least the clouds were there. In one case "clouds" were carefully seeded and nothing precipitated. This situation remains open.)

*The Chaplain and His Church.* The extension in 1953 of Social

Security coverage to state employees, but with specific exclusion of clergymen employed for the exercise of their pastoral office,[2] precipitated a new phase in the developing awareness of relationships of the chaplain and his church. It was noted at this time that in addition to being excluded from Social Security coverage the chaplain was in most instances excluded from the retirement program of his church body, except on the least rewarding self-contributory basis. This financial loss was symbolic of a more subtle loss of relationship between the chaplain and other clergymen of his church body. Special service, such as the chaplaincy, was viewed by one non-Kansas ecclesiastic as "getting out of step with our whole system." This was all too typical.

At about this same time the staff development program in the Kansas institutions had produced some of the tangible benefits sought for—including a significantly reduced hospital population—and the program turned to the long-delayed phase of buildings and capital improvements. Included in the general building plans were plans for chapels—only one of the state institutions then having a specific chapel building. The chaplains serving in the institutions shared in the rejoicing, but added the astringent question, "If the institutional chapel is meant among other things to symbolize the life of the church in the midst of a hospital or school, can it be built without the significant material participation of the churches?" The general response to this question was negative.

Retirement benefits, relationship with fellow clergy and chapel building plans—these focused concern again on the triad of relationships between church, churches, and institution. The chaplain's committee was now headed by Dr. Paul Pruyser, clinical psychologist at the Menninger Foundation, Topeka. Under his leadership a new, more formal statement of relationships was worked out, first by a sub-committee, then adopted by the plenary session of the Assembly of the Kansas Council of Churches. This action was then referred to the State Department of Social Welfare, Division of Institutional Management, to stand, along with the Memorandum of Understanding, as a basic document in the relationship of churches and the state. The statement as adopted, May 6, 1957, is listed below:

> The apparently unintentionally discriminatory exclusion (except under penalty conditions) of chaplains from protection under Social Security and most church pension programs was brought to the committee on chaplaincy about two years ago. More broadly, this specific problem was related to the general feeling of institutional chaplains that their ministry found few appropriate ways of relationship with church bodies. Again specifically, the committee was confronted by the need for some clear policy understanding about the responsibility and concern of the churches for the necessary facilities for the institutional ministry.

[2]This interpretation of the Social Security Act no longer stands and chaplains serving in "covered employment" may be provided for on the same employer-contributory basis as any other employee.

To these several problems the following is offered in way of report, clarification and proposal:

1. *Report:* The chaplains serving in public institutions are now covered by Social Security as employed persons, being regarded for this purpose as are any other civil employees. At least one church body has extended the regulations of its pension system and has provided for equal inclusion of chaplains serving public institutions; the normal participating contribution of a congregation local church being made from general church funds.

2. *Clarification:* The ministry of chaplains in public institutions should be regarded as an extension of the ministry of the church of the chaplain's ordination. It is recognized that such a ministry is exercised through the chaplain by the ordaining church on behalf of all the Protestant churches, to persons who by reason of their institutionalization are beyond the full services of the normal denominational, parochial church. There is, thus, a responsibility for this ministry shared by the church of ordination and the churches represented in the Kansas Council of Churches and the churches represented on the committee on the chaplaincy. This responsibility is further shared with the public agency in which the chaplain serves.

3. *Proposals:* To implement this understanding of shared responsibility it is proposed that:

*a.* The Kansas Council of Churches commend to the appropriate denominational bodies the equal inclusion of chaplains in church pension systems. Where such inclusion is dependent upon contributions from local churches on behalf of a minister serving them, it is urged that these contributions be made from general denominational funds or other sources appropriate to the denomination.

*b.* The Kansas Council of Churches and its committee on chaplaincy offer to the various chaplains whatever support can be given in their application for equal status with other ministers of the denomination.

*c.* The Kansas Council of Churches indicate its concern for suitable places of worship and religious activity in public institutions. Further, that the Kansas Council of Churches communicate this concern to the proper public authorities and indicate its desire to share in some significantly symbolic way in the cost of such places of worship. (T.W.K.)

## II. An Administrative Memorandum on Policies for Chaplains' Service

*A. Administrative Responsibility of the Hospital Chaplain.* Chaplaincy services in this hospital are conceived in the first place as general, non-denominational, and not marked by sectarian divisions. Thus, the state does not appoint a Protestant chaplain or a Roman Catholic chaplain or a Jewish chaplain. It appoints a *chaplain.* In this it follows a firm legal

precedent in many areas of the contact between church and state: the recognition of religious ministry as a legitimate need of public wards *but* the state's complete inability to differentiate *in principle* between the varieties of religious ministry. (The analogy of this conception to the status of military chaplains is clear. The contrast of this concept to that prevailing in some states, notably New York and Minnesota, is also clear.) The practical implication of this non-sectarian, all-faith, non-specificity of the hospital chaplain is that the chaplain has, *again in principle,* a significant responsibility for the religious ministry to *all patients,* regardless of their religious affiliation. To phrase this another way, the hospital chaplain is a public employee whose obligations and duties remain blind to sectarian differences.

B. *The Practical Specificity of the Hospital Chaplain's Religious Ministry.* Although the state does not (and should not) recognize *in principle* any differences between religious ministries, *in practice* it does and should recognize a few intransigent social-religious differences. At the same time it does not (and should not) recognize other less widespread and less intransigent differences except on the most temporary and expedient grounds. Thus, in practice, the hospital recognizes three faith groups whose ministry is so clearly differentiated by historic community usage as to demand similar practical recognition in the hospital: Jewish, Roman Catholic, and Protestant. Again, in practice, it does not (and should not) recognize the varieties of Protestant sects and denominations, nor the variety of Jewish groups, nor any distinctions of Roman Catholic clergy except on the most temporary and expedient grounds. Although, for political reasons, the hospital would seek to secure the unanimous support of the appropriate religious body for the clergy serving on behalf of a "faith group," it would seem apparent that, lacking such unanimity, the hospital must exercise its legitimate authority and choose between contending religious bodies. Further, it would appear that the hospital chaplain must maintain proper endorsement and status with the religious body which proffered his services to the hospital. The analogy of the diplomatic representative to a foreign government would seem to illustrate the nature of this practical relationship—such a representative serving at the pleasure of his own government *and* the government to which he is accredited. Again, there is ample precedent in the military services which demand "ecclesiastical endorsement" maintained in good order, and, at the same time, reserve to the military the authority of appointment, quota restrictions, transfer, retirement, promotion, etc.

C. *The Identical, Parallel, and Conflicting Interests of the Hospital and the Chaplain.* It is apparent that in many matters of concern the interests of the hospital and the chaplain are *identical.* Thus, both may be said to be identically concerned with the recovery of patients from illness. Further, where the interests are not identical, they may be adequately described as *parallel.* Thus, if the free responsible choice of a religious

identity—coming into communion with a church or religious community, observing its principles, and participating in its life—is a fair description of a *religious* goal in working with people. It has a striking parallel in the therapeutic goals of the hospital which seek to re-establish the patient in effective identity with himself, his sex, his community, etc. It is my experience that the bulk of the hospital chaplain's work is directed toward goals parallel (not identical) to the hospital's. Concomitantly, a large share of the chaplain's intellectual task is the relating of the hospital's goals to the specific goals which are peculiar to the church. It is at this very point where the chaplain is forced to be a clinician and a theologian. His failure as a clinician is signaled by complaints from the staff; his failure as a theologian is unfortunately usually only signaled by faint twinges of conscience.

An example of this need to rationalize the parallel goals of religion and the hospital can be found in the work of the chaplain on the hospital's children's services. Religiously speaking, the opportunity for a significant act of commitment to a religious identity is universal among religious groups —confirmation, first communion membership ceremonies, Bar Mitzvah, youth baptism, youth revivals, etc. In most cases such an act is associated with instruction in the faith. Such instruction is not just general information-giving; it is clearly preparatory to an act of specific "joining" or "being received" into a particular group. In many instances it reflects both the intensity and specific character of parental religious identity, but it is clearly portrayed *in every faith group* as a *responsible voluntary choice* of the child/adolescent. In fact, this free choice is the preeminent religious sign of coming into free maturity. The influence of parents is not to be minimized but the independence of the decision in these rites is paramount. Thus, simply to say that for administrative convenience we shall not countenance "religious changes" in our adolescent patients is to undercut the most vital character of "normal" religious activity in the adolescent "period of choice." Likewise, to defer any action in this matter until after discharge is to delay beyond the appropriate developmental period one of the significant experiences of taking on (or rejecting) the possible identities of maturity. Further, to limit religious instruction to non-denominational generalities is to miss the specific identity-demanding character of religious instruction (and probably end up either with an infantile kind of sweet gospel syrup or some over-intellectualized knowledge about comparative religions).

The dilemma is complicated by the clinical facts. Disturbed children seem to be especially troubled by the multiple problems of ego-boundaries, reality-testing, and even more primitive identities than religious. Relationships with parents—when present—are loaded with pathological overtones so that "free" choice religiously is no less determined by neurotic compliances and rebellions than the other "choices" they have made. Infantile reliance on "magic" thinking finds ready ally in some religious practices—

to the detriment of therapeutic attempts to support reality-testing. Religious identification is not theoretical; it is filled with both conscious and unconscious personages including the strongest feelings for the religious leader. Yet the whole structure of therapy (psychotherapy, at least) demands a focusing of feelings with the therapist. This page might be further filled by even more obsessive possibilities. It is enough simply to note that the goals of religion and treatment are parallel—disturbed children need to be helped to take on appropriate identity, internalize controls, and find social roots in the community. But at any one time, with any one patient, these parallel goals shared by both the hospital and the chaplain are not identical and their relationship warrants profound continuing cooperative work. It is my experience and conviction that such work would produce a rationalized harmony of efforts.

There are, however, certain limited incidents where the goals of religious ministry and the goals of the hospital are neither identical or parallel but *conflicting*. In this case I mean something other than the temporary confusion of purposes illustrated above under parallel goals. Here, I mean the irreducible tension of contradictions. The most specific examples are to be found in Roman Catholic medical-moral prohibitions on divorce, masturbation, sterilization, lobotomy, and in Orthodox Jewish rules on food. There are less clearly stated conflicts to be found in Protestant thinking—again involving drink, tobacco, dancing, marriage and divorce. Although such conflict of goals is rarely of importance, it would appear to me that the appropriate action of the chaplain follows by implication from the earlier-stated propositions: that the chaplain functions *in the hospital* under the authority of the hospital. This is the compromise of independence which is implied by his appointment. Where genuine conflict of goals stirs the conscience it must be communicated between the chaplain and responsible hospital authority at the most immediately responsible level (probably the ward physician). It must never be communicated through the patient. Where the seal of the confessional or the strictness of pastoral confidence is involved every effort should be made to secure reiteration of the material outside such restrictions in order to make possible team communication. Failure to be heeded by the hospital in these rare matters can be dealt with only by endurance or withdrawal-for-instructions to the parent church body. In any case, the hospital must, even in moral error, be endowed with authority to match its responsibility.[3]

[3]The burden of these historic dissents that became the majority opinion is that from its position of supremacy the state recognizes moral dissent for conscience's sake not as a natural right—for this would abrogate the whole concept of a society capable of making law—but as a social utility. The dissenter is granted his privilege of dissent because of its usefulness.

For a magnificent series of statements of similar thinking about the relationship between the state and conscience, see the series of judicial opinions written by Justices Black, Douglas, and Murphy in the Jehovah's Witnesses cases that were carried to the Supreme Court.

# THE MENTAL HOSPITAL CHAPLAIN AND COMMUNITY CLERGYMEN WORK TOGETHER THROUGH AN ORIENTATION COURSE

The Rev. Mack Powell

*Chaplain, Central State Griffin Memorial Hospital, Norman, Oklahoma*

It is the purpose of this paper to consider the mental hospital chaplain and his working relationships with local clergymen. Specifically, it will present briefly an orientation program which we have presented to clergymen in the communities of Oklahoma and point out how this program has brought about closer working relationships between the mental hospital chaplain and community clergymen. The most important part of our orientation program is a course eight to twelve weeks in length, each session lasting three hours. We have found that, through this relationship with clergymen in community churches, we have been able to develop very deep and effective working relations with community clergymen.

This orientation was begun at Central State Griffin Memorial Hospital in 1954. About twenty-five ministers with whom I was personally acquainted were invited to the hospital for this first course. This orientation was structured primarily as a lecture program. Our staff doctors and other personnel presented such topics as "Types of Mental Illnesses," "Meaning of Symptoms in Schizophrenia," "Danger Signals Denoting Mental Illness," "How Far Should the Minister Go in Counseling," "Referral Agencies for Psychiatric Help in the Community," and "Early Personality Development." Also, in this course, we studied actual case material to learn techniques in counseling. We presented very simple counseling techniques such as being a good listener and reflecting feeling areas communicated in pastoral contacts. Here it was interesting to note how, during the course, these men began to use these techniques in their pastoral contacts during the week, and that, as they reported back, they spoke of satisfaction never before received in calling on the sick and in their general counseling contacts.

I must confess that this program was begun originally to help build good friends for the institution in the community. Our hospital, in 1954, was having serious difficulties in maintaining a treatment hospital, as there were political possibilities that the hospital might again become a purely custodial type of institution. Though the building of good will was my

Paper delivered at the Protestant Section, Annual Meeting, Association of Mental Hospital Chaplains, May 13, 1958, San Francisco, California.

original purpose in beginning this program, it quickly became apparent that we were performing a very valuable service to the community, a service which was much larger than my own selfish aims in beginning the program.

I was utterly astounded at the expression of appreciation which came from the men who attended this first course. As I thought of the meaning of the course to these men, I began to realize how little most clergymen actually know about the meaning of, and reasons for, mental illness. Very few of the group had any idea that there was a close relationship between the problems of the mentally ill and their own counseling problems. Through the lectures which they heard, they came to recognize that there is a very close relationship between the problems which we face in the mental hospital and the problems which they deal with every day in their parish ministry. As we discussed the nature of mental illness, they gained new insight into the personalities in their churches and even into their administrative church organizations. As one Nazarene minister said, "Since taking this course I no longer conduct my Wednesday night prayer meetings as I once did, standing up front above the people, but now I sit down right in their midst and talk with them, not to them, about their problems where they are."

This course gave these men an opportunity to have a "give and take" with psychiatrists, psychologists, social workers, and other members of a psychiatric institution. One minister could not get over the honesty of one of the doctors when a session had run beyond its usual time and the minister said, "Fellows, we should go and not keep the doctor overtime," and the doctor said, "Don't use the doctor as an excuse; if you want to go, then go." The minister later commented, "I just can't be that honest." The ministers came to see the doctors as human beings, and the doctors came to have a much greater appreciation for the problems and professional roles of ministers. In fact our superintendent once made the comment, "I feel I have much more in common with clergymen than I have with some men in my own profession."

Out of this first course came demands from other clergymen that we continue this service. We have now conducted the orientation program four years and have had well over two hundred men of all faiths enrolled, including two Catholic priests, and we have reached ministers in all areas of the state.

This program has established a deep bond between the hospital and local ministers. After having heard our doctors speak and tell of their philosophy of treatment, and why they have certain kinds of treatment, our ministers are much more understanding. If a relative goes to a minister and tells him that he can't understand the kind of treatment which a member of his family is receiving at our hospital, the minister who has been to the hospital and taken our course understands what is happening.

The minister has become acquainted with the doctors, he has talked personally with them and knows what they are trying to do and why they are doing it. In this way the minister is not so likely to become overly identified with the parishioner and antagonistic toward our hospital and its program. Through the program the minister comes to know me, especially after having come to the hospital for 24 to 36 hours, and he feels free to call me directly about a member of his congregation who has been admitted. Very often the minister will tell me what has happened, and it is interesting to see the depth of his understanding into the person's problem.

The minister who has had the orientation can also be helpful with the families of the newly admitted patient. We are all acquainted with the fact that patients are inclined to want to get out of the hospital shortly after they are admitted. They say, "I am not sick and don't belong here." And just when treatment begins to become effective, to touch some of the patient's sore spots, and he begins to get better, he wants to leave. The patient at such times can make his family feel very guilty, and the family is inclined to want to take the patient from the hospital. The minister who has had our course is able to understand such maneuvering on the part of the patient, and he can help the family with its feelings about releasing the patient.

Many of the ministers who have been in the program are not hesitant about suggesting hospitalization to someone they know who needs help. Also, I have many of these ministers tell a person coming to the hospital that they know me and suggest that the person contact me upon his being admitted. Such patients, as I see them shortly after their admission, will say, "My minister told me to contact you." This bridges a gap for the patient between his church and the hospital; the hospital is not so strange to him because of my acquaintance with his minister.

There is a good deal to be said for the minister's coming into the hospital for ten or twelve weeks. Many of these men say, "This is just like a community. I had no idea the hospital was like this." Their coming to the hospital over such a period of time gives them a familiarity with the place and lessens their anxiety about the hospital. More than anything else, I feel that this kind of training experience with clergymen in the community develops a deep, close relation with the chaplain and the hospital. It creates an understanding that cannot be equalled by other kinds of contacts between a hospital chaplain and community clergymen.

One of the outstanding things our courses have done is to help ministers realize that, to be more effective in helping their people, they need to deal with their own personal anxieties. Many of these men have come to see that their own anxiety about needing to help very often gets in their way of being most helpful. Four clergymen have been so stimulated by this orientation that they have gone into psychotherapy themselves; they

expressed their need by saying, "If I am going to be of the most help to others, I must first get help." Three of these men have taken leave from their parishes for the summer and have taken our three months' full-time clinical training program.

The orientation program was so popular with some that they requested that we offer an advanced program for those in the orientation. Every two weeks about eight or ten of these men have come to the hospital. In this advanced group we concentrated on the problems of interviewing, actually interviewing newly admitted patients. Following the interviews, these patients, as well as the factors in their lives which led to their illnesses, were discussed by the group. We found, too, that these ministers were interested in discussing, in the group situation, some of their difficult parish problems.

We have sought to make the hospital a resource center for ministers in religion and psychiatry. We want our hospital to be a place where these men can feel that they can find help as they work mutually with us in this problem of helping people find peace from their emotional distresses.

Clergymen in the local parishes are lonely people; especially is this true as they attempt to deal with some of the problems they face in their daily ministry. As we help them in the loneliness of their ministerial problems we will build relationships for our hospitals, and the ministry to our own patients can be greatly helped through these contacts with community clergymen.

Also in our hospital we have offered one-day clinics each year for the past four years. At each of these clinics we have had an average of 120 ministers from over the state. For the programs at these clinics we bring in outstanding men in the field of pastoral counseling; this has helped cement the relationships which we have established in our orientation programs. These clinics have stimulated many ministers to come and take the orientation course.

We are now coming to the time when our mental hospitals are no longer places with high walls, cut off from the community. Our society is now recognizing that the problems of the mentally ill are closely related to the social and individual problems of our communities. We, as mental hospital chaplains, can help foster the understanding that the problems of our communities are common to the inner struggles of the mentally sick.

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## EDITORIALS

### A Further Appreciation of Dr. Boisen

In reviewing the distinctive contributions of The Reverend Anton T. Boisen, D.D., pioneer in the pastoral care of the mentally ill and co-founder of the clinical pastoral training movement, one finds relatively little attention given to what is perhaps his unique gift to this field. It is that one dimension to which he adheres in all his works, and that is the *theological* dimension.

Whereas others who have followed him, and to whom we are also greatly indebted, have plunged deeply into the fascinating and often-changing depths of psychology and dynamic psychiatry, occasionally straining if not losing their identity as *religious* workers, Dr. Boisen has steadily maintained that mental illness can best be understood in terms of the individual's *religious* orientation. Sometimes it has seemed as if he has been "a voice crying in the wilderness." The clamor of new and exciting theories about mental illness has drowned out again and again the prophetic voice which was first heard through the medium of that remarkable volume, *The Exploration of the Inner World.* Placed by some critics alongside of William James' *Varieties of Religious Experience,* Dr. Boisen's first book set forth insights and observations which earned him the gratitude and admiration of many fellow laborers in the vineyard, workers in the allied healing professions.

Throughout this book one encounters the theological dimension, the importance of the *religious* beliefs of individuals. "Theology," Dr. Boisen points out (p. 191), "has always been concerned with the motivating beliefs of men regarding their origin and destiny and their relationship to the universe. It has dealt with that which is supreme in the hierarchy of desires and values and with the choices which favor or impede maximum self-realization."

In order to sharpen his inquiry Dr. Boisen studied those who had passed through a crisis experience, believing that it is under such circumstances that "the individual is usually absorbed in the problems of why he is in the world and of his relationship to the forces upon which he feels himself dependent" (p. 192). Therefore Dr. Boisen found himself dealing with such subjects as "Man and His Destiny," "The Idea of God," and especially with "Sin and Salvation."

Those who have met this pioneering Christian teacher and who have sat at his feet know full well the extent to which he constantly kept before his students the importance of seeing human lives in a theological context. Instead of viewing religious beliefs as simply bizarre, symptomatic manifestations, Dr. Boisen argued vigorously and persuasively that an adequate understanding of these beliefs would unlock the mystery of an individual's present predicament.

So we find him (in Chapter XII of his most recent book, *Religion in Crisis and Custom*) addressing himself to such relevant topics of Christian doctrine as The Nature and Destiny of Man, The Fatherhood of God, Divine Revelation, The Person and Work of Christ, The Way of Salvation, and The Church. But he takes up these theological concepts always in terms of what he has chosen to call "living human documents." It is this test of reality, of human application—and documentation—that has enabled Dr. Boisen to keep Christian thought-forms from becoming sterile and meaningless.

In a positive sense the theological ideas set forth by this hardy trailblazer might be called fundamentalistic in that they reflect a more conservative view than that encountered in so-called "liberal Christianity." But their strength comes not from non-thinking rigidity but rather from the reality factor which renders these ideas particularly meaningful for those in crises situations. Who am I? Where did I come from? Why am I here? Where am I going? What do I do? Why do I do it? What does it mean to me? These are some of the basic questions of life, which Dr. Boisen maintains are pushed up to the surface for each of us as life crowds in on us and our freedom and self-realization are threatened if not actually blocked.

Perhaps the key-text in Christian revelation is to be found in St. Paul's second epistle to the Corinthians: "God was in Christ, reconciling . . ." It is to this ministry of reconciliation, the resolving of the conflict of sin and salvation, that the rich and industrious life of Anton Boisen has been dedicated. For him man's extremity is *always* God's opportunity, and to attempt to understand man apart from God is to fail before starting.

One of the principal reasons for the respect accorded Dr. Boisen's writings by members of other professions has been the fact that he has always written as a *religious* authority. We of the clergy have yet a very

great deal to learn from this courageous and pioneer spirit. It is encouraging to be reminded that what we have to learn came to be understood within the framework of our own distinctive function: the work of the pastor as he seeks seriously to understand and minister to the spiritual needs of his people. To this we have been called, and to this Dr. Boisen recalls us with his prophetic insights.

R.J.F.

# BOOK REVIEWS AND NOTICES

EDITED BY THE REV. ROLLIN J. FAIRBANKS

**Existence:** Edited by Rollo May, Ernest Angel, and Henri F. Ellenberger; Basic Books, New York, 1958. 445 pp. $7.50.

It is difficult to do justice to this book. Admittedly uneven, yet in so being it correctly represents its subject. While stylistically difficult, this, too, may constitute, at least in part, a reflection of the nature of the subject matter itself.

There is much in this presentation to trouble the complacent, and little to calm the troubled. The book communicates a judgment which cannot be evaded. It must, however, be judged in turn. This pair of facts leads to one of the greatest dangers, namely, that the book will become an occasion for attacks and counterattacks, rather than clear, creative, and critical thinking.

The volume contains ten chapters, three of which were written especially for it, and one of which was reprinted or translated from other publications. The three sections, entitled respectively "Introduction," "Phenomenology," and "Existential Analysis," constitute the skeleton. The musculature and nervous system are distributed as follows.

Part I consists of three original essays. Rollo May has written two of them, and he first places existentialism in historical perspective, and then puts existential psychotherapy within the perspective both of philosophy and psychiatry. He is strongest in his understanding of Tillich. In his second chapter, May reviews the contributions of existential psychotherapy and deals heroically with some of the difficult, hyphenated German concepts such as "being-in-the-world," "Transcendence," and others. He is aware of and emphasizes some of the dangers of existential psychoanalysis and neo-Freudian approaches. Yet he is also aware that it is a leaven which may well modify forever the development and course of psychotherapy. Henri Ellenberger writes the third original chapter. He relates perceptively and schematically the works of Husserl, Heidegger, Minkowski, Straus, von Gebsattel, and Binswanger, and the categories of time, space, causality, substance, and inner worlds.

In Part II, papers on phenomenology are presented. Minkowski eloquently reports the interpersonal relations of a depressed schizophrenic patient and his therapist. Erwin Straus presents a radical corrective to the projection theory of sensation and perception in his chapter on aesthesiology. Von Gebsattel brings alive the categories of thought of the compulsive patient.

It is to Part III, namely that on Existential Analysis which is dominated by three essays of Binswanger's, that the greatest reactions are likely to be evoked. Binswanger's first paper deals with an attempt at a systematic explanation of the existential analytic school of thought, particularly in the light of von Uexküll and von Weizsaecker. Then appear

the two tragic cases, that of Ilse and that of Ellen West. They are both reported as curious mixtures of well-documented detail and glaring absence of essential information. The case of Ellen West reads almost like a Greek tragedy, moving relentlessly on to its inevitable doom.

The case of Ilse presents problems to the mid-twentieth century reader who looks for doctor-patient relationship as an index of the modes of being of both the doctor and the patient, and of the dynamic interplay between them. Much of the case is presented in narrative form as if through the more or less objective, retrospective gaze of an ex-psychotic. It is therefore difficult to get the feel of the patient's participation in the interpersonal transactions along the way, and of the provocative and reactive responses of the others. This is particularly disappointing since one is looking for some flavor of the existential analytic form of treatment. Even the diagnostic approach seems to be more preoccupied with the verbal productions than with non-verbal communication. All this may be a consequence of the earliness of the case and the lateness of the report. Both of these cases are supposed to illustrate something philosophical, something ethical, and something psychotherapeutic. This reviewer is hard put to accept these cases as having made these points. They may bear multiple reading, however.

The final work is a long essay by Roland Kuhn on "The Attempted Murder of a Prostitute." Kuhn's clinical insight is blended with esthetic and philosophical sensibility. Here perhaps is the most convincing clinical paper in the book.

An annoying deficiency is the absence of original citations to the foreign language sources—an omission which still could easily be corrected by an addendum insert. The same is true of the bibliographies of the authors whose papers are included. It would have been helpful, too, to have in each instance in which a foreign technical term appears both a "translation" and the parenthetic representation in the foreign tongue. This would have been especially valuable since the editors themselves comment on the "untranslatability" of some of the expressions. This is particularly true of the punning German neologisms.

All in all, this volume serves several useful purposes. It declares in the first comprehensive book published in America what is existential psychotherapy's place in relation to both phenomenology and existential philosophy. It provides valuable translations of otherwise unavailable German and French classics, and, finally, it presents the best thinking of two of our ablest creative men in the field of evaluating historical and contemporary trends in psychopathology. Ernest Angel's translations are vivid and highly satisfactory. The undertaking of rendering impossible German into clear English is heroic and the outcome is usually successful.

EARL A. LOOMIS, JR., M.D.

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**The Cultured Man:** Ashley Montagu; World Publishing Company, Cleveland and New York, 1958. 284 pp. $3.95.

Ashley Montagu never fails to be stimulating, if not provoking, in his

writings. He also tends to be opinionated and to generalize unduly without presenting enough evidence to sustain his ideas. He shares with other social scientists the fate of a constant danger of either becoming lost in factual details or else pronouncing sweeping statements which represent scarcely more than wild speculation initiated by a little observation. This book combines, in two separate parts, both of these dangers. Pages 13 to 67 outline in an easily readable and at times even amusing journalistic style what the author considers the necessary requirements for the cultured man. It is quite evident and justifiable that Mr. Montagu thinks primarily of himself as the prototype of the cultured man, and therefore he feels free to start with his own views and assumptions. His vast knowledge and keen appreciation of cultural elements, especially those of our century, allow him to specify instructively what can and should be meant by the otherwise so hopelessly vague word "culture." As an anthropologist he has learned to observe and categorize various aspects of life which are included under this broad term. But quite unlike most of his colleagues, he does not avoid the complexity and delicacy of a study of an important part of our own civilization by escaping safely to the primitives.

The first section of the book is, therefore, highly recommended to anybody who would like to become aware of the cultural problems and potentials which are ours today. Certainly Mr. Montagu speaks from the rather elevated level of a very sophisticated intellectual who can afford himself the leisure needed for observation and reflection. It is not quite clear how the author conceives that a common man under the daily pressures of work and conformist relaxation should or could ever reach, on his own initiative and against the social pressure, that status of culture of which Mr. Montagu dreams.

On barely more than two small pages the writer introduces the second section, which deals with "your cultural quotient." A good two hundred pages are given to test questions from all possible areas of knowledge, by which every reader is free and invited to score his own level of cultural sophistication. In order to check himself and perhaps even learn something more, the answers are given later in the book.

It is the second part of the volume which forces us to register quite severe criticism. Hopefully Mr. Montagu is not so naive as to identify mere academic knowledge and even sophistication with genuine culture. What we know about things and events is one thing; how much we grow by this knowledge is quite another. Knowledge alone does not make a mature, well-integrated personality. It is regrettable that a man of the stature of the author should give refuge to the all too common Western disease of neglecting emotional and instinctual growth and refinement by an escape into a vast array of untied pieces of knowledge. An alert college graduate who has profited from a broad spectrum of different courses on still more different subjects stands a very good chance to proceed with flying colors through the rich questionnaire in this book. But he may be a hopeless idiot when it comes to recognition, acceptance, and expression of his own feelings, not to mention independent judgments which would allow him to achieve a courageous ethical view of life and to implement his moral convictions in creative actions.

Progressive education did not fail so badly solely because of the failure of the educators to impart structure and discipline to the learning process of the child. This kind of educational philosophy is at least equally detrimental in its failure to point out to the student by example and encouragement that to know means considerably more than mere brain exercise. One may be the biggest and most blasé storehouse of factual knowledge about practically everything without ever becoming aware that true knowledge means total involvement and calls for responsible decisions. Not that Mr. Montagu is unaware of this fact. On the contrary, on pages 28 and 29 he accurately blames the pre-world-war Germans for having had the best education in the world without its preventing them from producing a barbaric tyranny which is only out-dated by present-day Bolshevism. The trouble is that the author's own insights do not lead him very far. Even at the end of the first part we are merely invited to become refined enough to attain the level of Mr. Montagu's quite flat and academic brand of humanism.

This is all the more disappointing after the writer, almost with the voice of a prosecutor, has on pages 16 and 17 impressed strongly upon the reader the fact that the USA ranks highest in the world for homicide, violent crime, etc. Surely the author cannot be serious in believing that his conclusion can be considered a remedy for such deep-seated emotional and environmental problems, which may very well be the symptoms of cultural decay and decadence of a more serious nature than even Mr. Montagu seems to think.

We are quite indebted to the author for having pointed out one of the most fundamental problems of Western civilization. Willingly or not, his own point of view and proposals seem no improvement upon our own confusion on the topic. But this fact, once made clear, should become for us a true challenge to grow beyond a cultural complacency and begin the struggle with the deadly serious alternatives of the survival of Western culture through rejuvenation, or its sharing the destiny of previous cultures by a blind and gradual descent into the department of antiquities.

HANS HOFMANN

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**Alcoholics Anonymous Comes of Age:** By a Co-Founder; Harper, New York, 1957. 335 pp. $4.00.

The third major publication of Alcoholics Anonymous, this book is a warm, moving portrait of the first twenty years of a work which has grown to be world-wide in its outreach. The volume is not a dreary, historical sketch, but rather it describes the growth of an important, dynamic, social movement. The author sets forth in highly readable fashion some of the struggles and problems, structure, principles and program, as well as stories of the laity and other personalities from the fields of medicine, religion, and mass communications who have made real and lasting contributions to the movement. *Alcoholics Anonymous Comes of Age* should be read by all ministers and others who are skeptics or confirmed enthusiasts with respect to the power and influence of Alcoholics Anonymous.

M. DAVID RIGGS

**The Handicapped and Their Rehabilitation:** Edited by Harry A. Pattison, M.D.; Charles C. Thomas, Springfield, Illinois, 1957. 944 pp. $14.75.

Physical rehabilitation, a multi-disciplinary approach to the restoration of a disabled person to the maximum of his emotional, physical, social and vocational usefulness, has expanded rapidly since World War II. This volume consists of contributions by leaders in the disciplines entrusted with the rehabilitation of the handicapped, and aims to delineate the duties, obligations, and training of team members. The key-word is "Team"—a group of associates working cooperatively, with each member contributing from his specialized training. Various kinds of disabilities are thoroughly explored with the emphasis being placed on the kinds of treatment necessary to restore the disabled individual to his maximum functioning. The clergyman would find this a valuable reference work, particularly in the understanding of the needs of the handicapped in his parish. A chapter on psychotherapy would serve as a useful introduction to emotional problems, and it would assist him to recognize and make proper referrals when specialized help is indicated. Included is a very competently written chapter on the role of the clergy in rehabilitation, a subject usually neglected. The editor has adequately fulfilled his purpose, and no clergyman could read this volume without gaining understanding of his role as pastoral counselor.

EVERETT I. CAMPBELL

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**The Case of Jim: An Annotated Script of a Record on Counseling:** Julius Seeman; Educational Test Bureau, Nashville, Tennessee, 1957. One LP record and a 30-page script.

"Jim" was a college student in his early twenties who had been troubled by a speech handicap for years. Speech therapy did not seem to help him, and he turned to personal counseling which lasted about two years. The counseling process was recorded on tape, and passages from four of the interviews have been recorded on one LP record and printed in an accompanying annotated script. The record includes an introduction by the counselor (Julius Seeman of George Peabody College for Teachers) and brief interpretations of the counseling process after each interview portion. The annotated script has all the material which is on the record plus footnotes, which give a more detailed interpretation of the counseling, and a final section on "Counseling and Personality," which offers a brief theoretical formulation of personality development, change, and integration as related to the counseling experience.

The counseling is "client-centered" as conceived by Carl Rogers and his co-workers. The theoretical formulations are similar to those of Rogers. The interview portions which are recorded are well selected to illustrate the theory of counseling and the theories of personality change. Not enough material is included, however, to permit careful evaluation from other points of view. The record and script should be useful as aids to discussion of counseling and personality change. It may be difficult for persons not having a script to follow all that is said in the interviews.

HOMER L. JERNIGAN

**Success in Marriage:** David R. Mace; Abingdon, New York, 1958. 158 pp. $2.95.

The author, Professor of Human Relations at Drew University, is one of the pioneer marriage counselors in both Great Britain and the United States. His articles in a woman's magazine, like Paul Popenoe's, have been read by millions and they have given them good counsel. He has a simple, down-to-earth style that has enabled him to reach many audiences around the world. One is aware of a wise and sensitive man from reading his book.

He writes this work not for the professional counselor or pastor, but rather for the premarrieds, the freshly marrieds, and the couples involved in marital troubles which might bring them to a helping person. A pastor might use the book as a tool in counseling, putting it into the hands of any of these three groups. All sections are not relevant to all groups. But the couple approaching marriage will find help in the first two sections. The couple caught in marital conflict will find help in the last two sections. Professor Mace's method is to raise a question, say in the area of sex, and then to bring specific principles to bear on the question which will help the couple to gain insight into their problem. He uses excerpts from his own counseling experience more as illustrations of problems and problem-solving than as continuous case studies.

Mace's counseling procedure is eclectic as the book gives evidence with techniques drawn more from sociology than psychology. He does recognize the symptomatic nature of the couple's problems; however, he faces them as obstacles to be gotten around rather than as smoke screens behind which hide personality difficulties. The danger is that the couple in serious trouble might take his advice in a direct, "bootstrap" way, and neglect going to a counselor soon enough to get help. Mace cautions the couple along the way to seek out a helper if they find their difficulties too deep. And he writes an epilogue "To Those in Trouble" which underscores the need to get a marriage counselor. Were this chapter lengthened to an entire section, it would have been more quieting to this reviewer.

A book like this helps dispel ignorance and misunderstanding growing out of ignorance in the area of marriage and family relationships; only indirectly can it get at attitudes and motivations. This is the weakness of any book in this area. One hears of the husband, troubled in the area of sex, who consults a sex manual only to find that the book has driven a deeper wedge between himself and his wife. This does not say the manual serves no purpose, but it is better coupled with some counseling help.

The pastor will find this book, like Mace's earlier *In Holy Matrimony,* a welcome addition to his lending library shelf. Its best use will be, however, not as a substitute for, but rather as a complement to, counseling.

CHARLES W. STEWART

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**Facts and Theories of Psychoanalysis:** Ives Hendrick, M.D.; Alfred A. Knopf, New York, 1958. 357 pp. $6.00.

In this revised, expanded, and rewritten third edition of Dr. Ives

Hendrick's book, *Facts and Theories of Psychoanalysis,* we are presented with the entire terminology of the traditional psychoanalytic concepts. The main interest of the author is the field of psychoanalysis. He certainly adheres to the title of the book, for there is hardly any area of the Freudian scheme of thinking which has been overlooked in his discussion, including the history, development, and impact of psychoanalysis from the time of its inception by Freud.

This book is of special interest because of the well-written, concise manner in which such a large body of material has been organized in so few pages. Unlike most volumes on the theory of psychoanalysis, this one has interesting and well-presented case material interspersed throughout its content, which constitutes a great aid in making the facts and theories more illuminating. For the minister who is interested in an introduction, or who wishes to acquaint himself better with psychoanalytic thought, this book is highly recommended.

L. MACK POWELL

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**Emotional Dynamics and Group Culture:** Dorothy Stock and Herbert A. Thelen; New York University Press, New York, 1959. 296 pp. $6.00.

This volume consists of a thorough report on a responsible research project (conducted for the National Training Laboratories) which focused on the individual in relation to the group. The findings give further support to an original premise that group interaction can be more adequately understood when seen as involving *both* work and emotionality, the latter regarded in terms of W. R. Bion's concepts of fight-flight, pairing and dependence. The conclusions also indicate helpful direction for the practitioner without yielding to the "how to" temptation.

Although an undeniably valuable report, it is probably too advanced for most clergymen, and the detailed research combined with the language of the sociologist does make the reading tedious to all but the more advanced student.

GEORGE L. PEABODY

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**Human Nature under God:** Oren Huling Baker; Association Press, New York, 1958. 303 pp. $4.50.

In a generation when the predominant theological pendulum is still tolling man's helplessness and despair, it is most refreshing to be reminded that human nature under God is created for unimaginable possibility by a God of boundless grace. This is one of the services Dean Baker has performed for us in this book. Man's perversity, his self-seeking tendency, and his ambiguity are all clearly acknowledged. But the perversity is part of the risk of freedom; the self-seeking can be transcended and redeemed by the God of grace Who is working to create persons; the crises and conflicts of life can be fruitful, if painful, occasions for growth into personhood. Other books by other authors have carefully analyzed man as sinner. While not denying this reality, Dr. Baker's reading of some of the meanings and possibilities involved in being created in the image of God helps us to see ourselves whole.

The book is an essay in the "adventure of personality," as the subtitle suggests. Part I, "The Soul of Israel," traces the adventure through various stages of emerging self-consciousness to the fulfillment of free, self-transcendent personhood in Jesus. The epic of Israel's development is seen to be parallel to that of Everyman. The rich variety of human life—any man's life, potentially—is retold in vivid fashion in the accounts of the patriarchs, Moses, the kings and the prophets, and finally Jesus and Paul. The author has a rare gift for showing forth the vibrant contemporary meaning of the Bible. The reader will discover an unexpected bonus here, in the wealth of material that is homiletically suggestive.

Part II, "Man the Person," is an interdisciplinary discussion of man the self and man the person, utilizing and correlating insights from biology, sociology, psychology, and theology.

The central theme of *Human Nature under God* revolves about the author's distinction between self and person. The major issue of human life is seen to be internal. The chief alternatives are between contentment with the biosocial self and undertaking the awesome promising burden of autonomous personhood. The latter truly describes man, and is his destiny under God. This distinction, initially very puzzling to this reviewer, became clearer as the author returned to elaborate the theme again and again. In its gross outlines, the biosocial self emerges out of social interaction (as described by G. H. Mead); it is reactive to its internalized, generalized other; its criterion of judgment is the society which produced it; it is therefore social not personal; to use a term Baker does not use, one could describe its behavior and attitudes as heteronomous. The person, on the other hand, is that "component" of the personality that emerges out of belief as the creation of God; the person is reflexive, able to transcend the survival demands of the self in the service of purpose and destiny; as a person, one is a free center of decision; the person puts his own stamp on what he perceives; his criterion is responsible obedience to God; he is autonomous. "Any society can produce a self; ultimately, only God, using self, can create a person" (p. 262). How this occurs in Biblical man and contemporary man is the adventure of this book.

Although the general features of the self-person distinction are clear enough, a serious question to this reviewer is whether the distinction is too cleanly made. Is not reflexive self-transcendence, one of the marks of personhood, intrinsic to the process of emerging self-consciousness? The moment I can distinguish between the "me" which is my social past internalized, and the "I" which is making the judgment, I am exercising something of the autonomy which in the area of responsible decision marks me as a person. What is not as clear as one would like in this book is a statement of the continuity between "nature" and "human nature." Where and how in the processes that precede and undergird human personhood is God working? If nature and God are indeed separable concepts, what is their relation? The questions present themselves because the author does not disparage nature nor seem to be arguing for radical discontinuity. Instead, the destiny of man under God to become a person is part of his nature, not something imported and overlaid upon it.

There is much in this book to stimulate thinking. The issues are live

ones. For instance, if, as Dean Baker indicates, man comes to full awareness of himself only in relation to God, what does this mean for counseling in which the usual goal of self-awareness does not assume awareness of God? The book as a whole is a contribution to the current inner- and outer-directed discussion. There are provocative excursions into the meaning of time, confession, repentance, forgiveness, obedience, faith, joy, and worship. The whole is written with clarity and, when describing the achievements of Israel and the personhood of Jesus, with lyric eloquence.

PAUL NICELY

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**Economics of Mental Illness:** Rashi Fein; Basic Books, New York, 1958. 164 pp. $3.00. (No. 2 in the Monograph Series of the Joint Commission on Mental Illness and Health.)

This book is concerned with estimates of direct and indirect costs of mental illness in the United States, and provides a series of careful measures of it. The minimum direct cost is $1.7 billion a year, to which other items should be added if they could be estimated. Indirect costs from loss of income run above $700 million annually. Few non-economists will be interested in the details of these estimates as Dr. Fein patiently puts them together.

More relevant to the readers of this *Journal* is Dr. Fein's conclusion that it is probably not a wise economy to attempt to reduce the direct costs of mental illness. More psychiatrists in state hospitals may actually cost less than fewer, as patient-hospital-days are reduced with earlier discharges.

Persons interested in the rapidly evolving treatment of mental illness will find little reference in the study to the impact of tranquilizer drugs or of group therapy on the costs of mental illness.

CHARLES P. KINDLEBERGER

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**The Image Industries:** William Lynch, S.J.; Sheed and Ward, New York, 1959. 159 pp. $3.50.

Because the movies and TV are not only more influential among the mass media today than anything else, but also owned and controlled by a very small group of people, Father Lynch's little book should be read and pondered. He refuses to write off popular media as *kitsch* (junk) too mean for the artists' and critics' concern, and he also denies any claims of autonomy—*ars gratia artis*—for those who produce entertainment. As things are going, he sees an alliance of TV, the cinema, and Madison Avenue materials, with the result that these mass media are diseased in four ways: fantasy obscures reality, flatness irons out the difference between high and low values, imagination is fixed and hemmed in, and "spectaculars" falsify the truth with their unreal magnificence. He believes that the makers and manipulators of these media have contempt for both workmanship and their audiences. Because there are only a few nationwide channels and hook-ups their influence wipes out taste, and regional and cultural differences: healthy pluralism is replaced by a vague sameness

called Americanism—either an abstraction that cannot exist or a cheap creation which ought not to exist! Father Lynch challenges (perhaps correctly) Maritain's view that art is for the good of the work, ethics for the good of the man: he insists on putting them in a tandem harness. In spite of some silly things he says about Protestantism (e.g., page 151), and even though this is only the bare bones of a thesis, the book is valuable, seminal. His hope is that an entente can be set up between artists, critics, theologians, and universities, which will recover depth of treatment and ideological pluralism and save the populace from "least common denominator" pap. Ora pro nobis.

JOSEPH FLETCHER

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## OUR REVIEWERS

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## NEWS AND COMMENTS

The Rev. Keith Keidel left his position as Chaplain-Supervisor at Englewood Hospital, Englewood, New Jersey, on September 1 to become the Chaplain at Brooklyn Methodist Hospital in New York.

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The Religious Research Association announces a new journal, *The Review of Religious Research,* published quarterly. The Editor is Frederick A. Shippey of Drew University. Those interested in subscribing should write to Miss Carolyn J. Odell, Secretary, P. O. Box 228, Cathedral Station, New York 25.

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The Rev. Thomas W. Klink, Chaplain-Supervisor at Topeka State Hospital, Kansas, assumed duties as Chaplain and Coordinator of Graduate Studies in Religion and Psychiatry at the Menninger Foundation in Topeka on May 1. Chaplain Klink, who began work at Topeka State Hospital in 1951, will continue supervision of clinical pastoral training there through the summer quarter, 1959. The new position to which he goes will include coordination of a new program of Fellowships in Theology in the Menninger School of Psychiatry. The Fellowships, for twelve-month periods, will be open to clergymen who are candidates for doctoral degrees in any relevant field of advanced study. Visiting faculty to the program during 1959-60 include Father Charles Curran, Loyola University, Chicago; Rabbi I. Fred Hollander, Yeshiva University, New York; and the Rev. William B. Oglesby, Jr., Union Theological Seminary, Richmond, Virginia.

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The Rev. Archibald F. Ward, Jr., formerly Chaplain-Supervisor under the Council for Clinical Training at Eastern State Hospital, Williamsburg, Virginia, has taken the position of Director of Adjunctive Therapy at Blackfoot Hospital South, Idaho.

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The Rev. George R. Tolson will leave the State Hospital at Greystone Park, New Jersey, on October 1 to become Chaplain at the State Penitentiary, San Quentin, California.

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The Rev. Charles Hall, Jr., has gone to the position of Chaplain-Supervisor at Topeka State Hospital, filling the vacancy left by Chaplain Klink's going to the Menninger Foundation. Chaplain Hall was for the past year an Associate Chaplain-Supervisor at Austin State Hospital in Texas.

# AN IMPORTANT ANNOUNCEMENT

The Council for Clinical Training will relocate its Central Office to the new Interchurch Center in December of this year. This nineteen-story building in the Morningside Heights section of Manhattan will serve as headquarters for many denominations as well as the National and the World Councils of Churches. The Center symbolizes the growing Protestant solidarity in America and the work of Protestant and Orthodox Churches in every corner of the world.

Members of the Council for Clinical Training are constantly engaged in a living experience of Protestant fellowship and ecumenical concern. Students taking training in Council-accredited centers come from every denomination and seminary. Their internship under supervision in mental hospitals, general hospitals, prisons, and clinics brings together their questions and commitments, struggles and achievements as they undertake pastoral care for people in crisis. Thus the Council feels that relocating its headquarters to the Interchurch Center is most fitting and looks forward to fruitful association with other residents of the Center.

The Center stands across the street from famed Riverside Church and within a few blocks of the Cathedral of St. John the Divine, both Jewish and Union Theological Seminaries, Teachers' College, and Columbia University. The cornerstone of the Center was laid last October 12 by the President of the United States. The stone is inscribed, "This stone is from the Agora in Corinth where many . . . hearing Paul, believed."